MEDICAL FOSTER CARE: AN ETHNOGRAPHY

By

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The purpose of this ethnographic study was to ascertain what is involved in the process of medical foster parenting from the foster parents' perception. The study described the stages that medical foster families go through as they define roles, build relationships and disengage themselves from children who are returned to biological families or regular foster care placement.

The research took place in a southeastern urban area where medical foster care was developed to prevent boarding of abused and neglected children in hospitals when biological families are unable to give safe care and no suitable alternative placements are available. The sample consisted of eight nurses and their spouses who were licensed as medical foster families for abused and neglected children with severe health problems. Ethnographic data were collected through participant observation and in-depth interviewing of medical foster parents.

Themes of behaviors, feelings and needs emerged as medical foster parents interacted with biological parents to provide medical treatment, role modeling, parent education and advocacy. Medical foster families were motivated by pragmatic, noble and religious intentions, but their initial reaction was characterized by feelings of disquiet, guilt and isolation. Routinization of medical care was a prerequisite for attending to psychosocial needs of children and biological parents. Medical foster parents faced the reality of biological families as they prepared for children to be returned to their homes. The informants went through stages of detachment from foster children but in the process experienced dissonance and existential contradictions. The medical foster parents reported unanticipated stresses associated with lack of professional recognition, contradictions in the bureaucratic systems and conflicts with biological parents. Measures to enhance coping strategies, support systems and rewards of the medical foster care experience were described.

As applied research, the study has implications for nursing education, community health practice, medical foster parent training, social service agencies and for other professionals who work with medical foster families.

CHAPTER I

INTRODUCTION

Statement of the Problem

And he who gives a child a treat
Makes joy bells ring in Heaven's street,
But he who gives a child a home
Builds palaces in Kingdom come . . .

John Masefield, The Everlasting Mercy

The purpose of this ethnographic study was to ascertain what happens in the medical foster parent setting and to examine the stages that the foster families go through as they define and internalize their roles. The first medical foster care model was developed in a metropolitan southeastern city to provide an alternative to hospital institutionalization of abused and neglected children and to provide education for biological parents. The purpose of this study was to understand the experience from the viewpoint of the medical foster parents. This study was undertaken to explore themes in the behavior of medical foster parents and to discover if there are phases in the foster parenting experience.

Abused and neglected children with recurring health problems often remain hospitalized for months on end because there are no suitable alternative community resources. Medical foster care, a

new concept of foster parenting, was designed to reduce inappropriate hospitalization of abused or neglected children, provide environments in which children can regain their health and a sense of well being and to strengthen dysfunctional families.

Medical foster parents were selected on the basis of the following criteria. One of the foster parents had to be a registered nurse, licensed to practice in the state. The family had to be willing to accept a child needing medical care into their home for an extended period. In addition to medical duties and the normal activities of parenthood, medical foster parents had to agree to work closely with biological families to promote the eventual reunification of foster children with biological parents. The medical foster care model was developed with the assumption that through education and the role modeling examples of foster parents, biological parents could improve their parenting skills to eventually provide a safe environment for their children.

Ethnographic Questions

The focus of this research was on medical foster care families. The guiding question of this study was: What is involved in the process of becoming a medical foster parent? From an analysis of ethnographic data collected in the early stages of this research, review of pertinent research literature and an examination of my own experience working with medical foster care families, the following preliminary questions were developed.*

*In keeping with the ethnographic tradition of research which involves participant observation, the dissertation is written in the first person.

1. What motivates nurses and their spouses to become medical foster parents?

2. What roles do medical foster parents assume?

3. What are the phases of the foster parenting experience?

4. Do medical foster parents bond to a medical foster child or distance themselves during the parenting experience?

5. How does having a medical foster child influence family activity and relationships?

6. What the stresses medical foster parents experience in relationships with medical foster children, biological parents, family members, and professionals, and what strategies are used to cope with such stresses?

7. What are the rewards of medical foster parenting?

8. What are the behaviors described by medical foster families that enhance relationships with biological parents?

9. What behaviors are exhibited by medical foster parents when they relinquish children and return them to their biological families?

10. How do medical foster parents view dysfunctional parents whose children are in their care?

The questions listed above guided fieldwork observations and interviews with medical foster parents. As the study proceeded, additional structural questions emerged that served to further clarify the research problem. Some of these are

1. What are foster parents' initial reactions to bringing a foster child into their home?

2. What are some of the unexpected situations that the foster parents encountered?

3. What worries do medical foster parents have regarding the care of their foster child?

4. At what point do medical foster parents begin to feel attachment to the child?

Need for the Study

There is a paucity of research that examines the experience of foster parenting from the point of view of the foster parents themselves. Because medical foster parent programs are so new, no research on the process of medical foster parenting has been conducted; research is necessary if the medical foster care programs are to be successful. Qualitative research can provide the information needed for program improvements and supply promising hypotheses for further study.

The Need for Medical Foster Care Programs

Studies show that children in this country are frequently shifted from one foster home to another, and are sometimes left to drift in the foster care system (Maluccio, 1981). Foster care that only protects children without attending to the needs of biological families results in continued separation of children from their own families (Knitzer, Allen, & McGowan, 1978). Medical foster care includes biological families in the treatment plan.

According to recent figures, 1.3 million children are abused and neglected in the United States each year (Sixth National Conference, 1983). Over 500,000 children are in foster care or out-of-home placement in this country (Knitzer et al., 1978; Olsen, 1982).

Since the advent of the 1971 child abuse and neglect reporting laws, the five county area in which this study was conducted has consistently had a higher rate of reported cases of child abuse than any other area in the state (Jolly, 1984). More children from this district are placed in foster home care than from any other district in the state. Approximately 5 percent of foster care children have dysfunctional families and acute health problems that necessitate extended hospitalization. The cost of long-term hospitalization to the state and to the social intellectual development of foster children is immense.

Abused and neglected children with acute health problems often remain hospitalized indefinitely when dysfunctional families are unable to provide care and alternative care is not available. Such children not only suffer the trauma of abuse and neglect, but are victimized by the lack of community resources. Institutionalization of children in a restrictive hospital environment creates psychological problems for children, disrupts the family, consumes hours of nonproductive agency and professional time, and causes vast expenditure of public funds.

Because of lack of training, typical foster families are not prepared to provide the daily care and evaluation of children who need tube feeding, tracheotomy care, sterile dressings and physical therapy. Generally, there has been little emphasis on close interaction between foster families and biological parents although research has demonstrated the need for such involvement (Maluccio, 1981).

In 1980, a program of medical foster care was developed by the Children's Crisis Center, Inc., as an alternative to hospital institutionalization of abused and neglected children with acute health problems. Foster families were recruited from among families in which one parent was a registered nurse and both parents were willing to work closely with biological parents. The foster families were expected to provide nurturance, role modeling, education for biological parents, and advocacy. It was hoped that close interaction between medical foster families and dysfunctional biological parents would be maintained to establish trust and protect the parent-child bond. Visitation of biological parents in the homes of medical foster families was encouraged to enable biological parents to practice the necessary care under supervision.

The goals of medical foster care are to reduce inappropriate hospitalization, reduce the length of stay in foster care after hospitalization, and improve parenting skills of dysfunctional families. The average cost of a month of medical foster care in 1983 was $1000 per month (foster care at $346.00 plus a range of $400.00 to $1,000.00/month for nursing care). The average cost of a month's hospitalization in the same geographical area was $10,500 (Whitworth, Foster, & Davis, 1983).

In the past, foster parents have often been viewed as part of the client system rather than part of a professional team. Foster families who are able to accept a role of professional responsibility as part of an interdisciplinary team are urgently needed in the field of foster care (Ryan, McFadden, & Warren, 1981). This ethnographic

study generated evidence that such families can provide therapeutic, nurturing environments and demonstrate effective interpersonal relationships.

Nurses as Foster Parents

Because of their educational background, clinical expertise and life experiences, nurses are ideally suited to accept the professional responsibility of becoming medical foster parents for abused and neglected children with acute health problems. Nursing education is grounded in communication theories, teaching-learning principles, family theories, stress and adaptation, systems and change. Nurses are licensed through the Nurse Practice Act. In this state the "practice of professional nursing" means

> The performance of those acts requiring substantial specialized knowledge, judgment, and nursing skill based upon applied principles of psychological, biological, physical and social sciences which shall include but not be limited to:
>
> (1) The observation, assessment, nursing diagnosis, planning, intervention and evaluation of care; health teaching and counseling of the ill, injured or infirm; and the maintenance of health and prevention of illness of others.
>
> (2) The administration of medications and treatments as prescribed or authorized by a duly licensed practitioner authorized by the laws of this State to prescribe such medication and treatments.
>
> (3) The supervision and teaching of other personnel in the theory and performance of any of the above acts. (Chapter 464 Nursing, State of Florida)

The professional nurse/client relationship can be used to strengthen the self-concept of a mother whose child requires care that she is unable to provide. The nurse's position of authority and respect allows the biological mother to maintain her

self-esteem while listening to the advice of a professional nurse rather than another parent without professional credentials.

In 1980 three children were identified who would have been hospitalized indefinitely due to burns, a tracheotomy, a gastrostomy and malnutrition resulting from abuse and neglect. Three special foster families were recruited where one parent was a registered nurse and both parents were willing to work closely with the biological parents. Intensive psychological and social services were provided by the program. As a result, two of the children returned to their parents in less than 24 months when the average stay in regular foster care in this state was 42 months. The parents were rehabilitated to the point that social services were no longer needed. Following the resolution of acute medical problems, the third child went into regular foster care.

Based on the success of using special foster homes and intensive treatment for biological parents, the medical foster care program was expanded in 1983 through a Federal Grant awarded by the Department of Health and Human Services. The goals are to provide nursing care and to strengthen families through intensive treatment so that children can return to safe and nurturing homes (Whitworth, Foster, & Davis, 1983).

Research is needed to grasp the perception of the medical foster parenting experience. Qualitative research techniques were used to explore behaviors, to find meaning and predictability and to provide insights into medical foster care from the view of the participants. This research explored underlying assumptions

of behavior through participant observation and in-depth interviewing of medical foster families. The general problem for the study was "to discover the cultural knowledge" medical foster parents use "to organize their behavior and interpret their experience" (Spradley, 1980, pp. 30-31).

CHAPTER II

LITERATURE REVIEW

Medical foster care is a new concept of foster parenting; therefore, no previous research has addressed this complex treatment modality. A review of literature on the effect of long-term hospitalization and on the process of foster parenting led to the development of the questions that guided this research. Previous studies have reported that institutionalization of children in hospitals is detrimental to their growth and development (Stocking, Rothney, Grosser, & Goodwin, 1972; Douglas, 1975; Lynch, 1976; Quinton & Rutter, 1976; Carbino, 1980; Pill, 1977; Tekely & Dittemore, 1978; Starbuck, Adelson, & Hustace, 1979; Trout, 1983). Spitz (1945) described a syndrome of depression in children secondary to long-term institutionalization and coined the term, "hospitalism." Children, discharged from hospitals into medical foster care, were likely to exhibit behaviors associated with abuse, neglect, and lengthy hospitalization.

The literature suggests that typical foster parents are not well educated, do not attain a professional status and are viewed by service providers as part of the client system (Carbino, 1980; Hampson & Tavormina, 1980; Enos, 1982). One member of each medical foster family is a professional nurse. The research questions

explored relationships of medical foster parents with other professionals to determine the degree of status these foster parents perceived. Motives and rewards of foster parenting were discussed by Hampson and Tavormina (1980) and bear on the research question that asked what motivates medical foster parents.

Literature on the fostering process identified the disruptive effect of foster children on family patterns of activity (Wilkes, 1974; Barsh, Moore, & Hamerlynck, 1983). Patterns of coping and the need for situational support systems were noted (Littner, 1978; Wilkes, 1974; Barsh, Moore, & Hamerlynck, 1983; McCubbin, McCubbin, Patterson, Cauble, Wilson, & Warwick, 1983; Berkin, 1979). Edelstein's (1981) report of foster parents' grieving when children returned home provided the basis for questions that explored medical foster parents' behaviors when they relinquished their foster children. The literature provides a rationale for frequent visitation of foster children with biological parents (Bowlby, 1961; Littner, 1975; Stein, Gambrille, & Wiltse, 1977; Fanshel, 1975; Davis & Bland, 1978; Ryan, McFadden, & Warren, 1981). This qualitative study examined medical foster parents' view of dysfunctional families whose children were in their care and asked what behaviors enhanced relationships with biological families.

Like a mosaic, the review of literature describes previous pieces of research on foster parenting. The current study is intended to add to the field of research through an ethnography of medical foster care.

There are no exact figures as to the number of children who are cared for through out-of-home placement, but a Children's Defense

Fund study estimated the number to be one-half to three-fourths of a million (Knitzer, Allen, & McGowan, 1978). Over 500,000 children live in foster homes (Knitzer et al., 1978; Olsen, 1982; Maluccio, 1981) while others live in residential treatment centers, schools or institutions. Some children are left in hospitals for months on end not because of sickness but because there are no appropriate homes available. In a project of the Children's Defense Fund, the age, sex, race, type of placement, length of placement, number of moves and legal status of foster children were studied in a random sample of 140 counties in the United States. National policies, regulations and legislation were also analyzed. Findings of the study showed that "a pervasive, implict antifamily bias often shapes decisions about children at risk of removal or in out-of-home care" (Knitzer et al., 1978, p. 5). Biological families are not encouraged to visit their children and are sometimes discouraged from attempting to maintain contact. Biological families generally are not kept informed about their children's progress and children may be moved from one foster home to another without the biological parents' knowledge.

The study concluded that

> Too many children are in institutions. . . . Despite national rhetoric favoring deinstitutionalization, federal funds are often not used to ensure care in the least restrictive setting. The availability of Medicaid funds often serves as an incentive to keep children with special needs in hospitals or nursing homes when foster home placements might be more appropriate. (Knitzer et al., 1978, pp. 6-8)

Hospitalism

A study of 1,561 children who were hospitalized continuously for four months or longer suggested the longer the hospitalization, the greater the probability that the child is either critically ill or in the hospital for reasons other than those medically justified. Economically and socially disadvantaged children are more likely to be hospitalized and stay in the hospital longer than middle class children. Such children are often kept in hospitals even after their medical condition has improved because the hospital staff and appropriate state agencies are reluctant to send unhealthy children back to families that are ill equipped to care for them. Poorly educated parents may be unable to provide proper medical care. Poverty and poor housing may further threaten the health of the child. Single or divorced parents may not have the time or the resources to look after a child who is ill. Research by Pill (1977) has shown a negative parent attitude in poor family situations may work to increase the length of a child's hospital stay.

The hospital environment is not suited to long-term care of children as it cannot meet the social and emotional needs of children. Routine care may be given by a number of different individuals including nurses' aides or technical assistants. Hospitalized children lack the consistent care that one or two parent figures can offer. Thus, the hospital is inappropriate as a substitute home (Pill, 1977).

In a 1976 survey of hospitals in New York State, 21 hospitals reported that 94 well children were being boarded in pediatric units. The children were predominately non-white and from single parent, low income families. Abuse or neglect was a factor in 30 percent of the cases. The period of hospitalization ranged from one month to over four years. Such children "live in neglect and oblivion," and lose hope of ever returning home (Cerminaro, 1977).

Douglas (1975) studied correlations between the early hospitalization of children and later disturbances in behavior and learning. One thousand and twenty children in Great Britain were studied for a period of 26 years. Researchers collected data on reading test scores, teachers' assessments of children, children's delinquent behaviors, progress in school, graduation rates, and subsequent employment. Douglas found that children who were admitted to hospitals during their first five years, when compared to a control group, were more likely to have experienced one or more repeated hospital admissions between age 5 and 15, have a physical disability, be male, come from large families, have fathers who worked as manual laborers, and have parents who did not show interest in their children's school work. The study suggested that a hospital admission of a week or longer or multiple admissions before age five were associated with behavioral problems, reading disabilities, delinquency and job instability. Douglas recommended that home care always be considered as a substitute for hospitalization of children (1975).

Quinton and Rutter (1976) also examined the relationship between hospital admissions of children and later emotional distress, in an

attempt to replicate the findings of Douglas. All the 10-year-olds living on the Isle of Wright in 1969-1970 and all those living in an inner London borough were screened through a teachers' questionnaire to identify children with behavioral or emotional problems. A random sample of 399 children with normal scores and a random sample with scores which indicated emotional or behavioral problems at school were then studied in depth. Measures included behavioral or emotional deviance scores obtained from a questionnaire for teachers. The questionnaire was found by Rutter through earlier research to be valid and reliable. Interviews with the children's mothers produced data related to family relationships, marital discord, medical history, communication patterns and the emotional state of children and families. Data regarding hospitalization of children were collected retrospectively. The child's age and reason for admission--if the child was hospitalized for a week or longer--were coded.

The findings confirmed Douglas' earlier reports that single hospitalizations were not related to emotional or behavioral problems, but multiple hospital admissions, including at least one during the preschool period, were statistically significant for emotional problems and more common with behavioral disturbance. While 37.3 percent of children who had single hospital admissions were from "disadvantaged homes," 56.1 percent of those with multiple hospital admissions were from disadvantaged homes. However, even after standardization on the disadvantaged index, both the high and low psychosocial disadvantaged groups with multiple admissions

had a significantly larger number of emotional problems. Findings also indicated that children who were diagnosed as showing psychiatric disorders had been hospitalized on multiple occasions prior to age 5, compared to 2.9 percent of psychiatrically normal children even after controlling for psychosocial differences (Quinton & Rutter, 1976).

According to Quinton and Rutter's (1976) findings, there is an interactive effect between psychosocial status and hospitalization. Children from disadvantaged homes are more vulnerable than others to the stresses of repeated hospital admissions.

In a classic report of 123 infants housed in a nursery, Spitz (1946) described a syndrome of depression that was severe in 19 infants and mild in 26 infants. Over a period of 12 to 18 months, children were observed weekly for a total of 400 hours per child. In each case, the depressed child had been left in the nursery for months with infrequent visits by the mother. Four to six weeks after separation, the babies began to withdraw, lose weight, exhibit insomnia and increased susceptability to colds. Spitz (1946) noted a "frozen rigidity of expression" (p. 314), a slowing down of activity, reduced response to stimuli and finally, a state of dejection and stupor.

Spitz (1945) earlier coined the term "hospitalism" when reporting the detrimental effects of institutional care on infants. The infants studied were less than one year of age and were institutionalized for reasons other than illness. A longitudinal study of the children included 69 infants in a penal nursery and

61 infants in a foundling home. Two groups of noninstitutionalized children of the same age group were used for controls.

The nursery was an institution for delinquent girls, many of whom were pregnant on admission. Infants in the nursery were given toys, the rooms were bright, and the view of surroundings included the outdoors and other babies in the nursery. The young mothers and pregnant girls took care of bathing, feeding, and caring for the babies. The foundling home was established for mothers who could not financially provide for their children. No toys were evident, and bed sheets were hung over the railings of the cribs isolating the children from the outside. Babies lay on their backs until indentations were worn into the mattresses that eventually prevented them from turning over. The developmental quotients of these infants went from an average of 124 in the first four months of their first year of life to an average of 72 in the last four months of their first year of life. The children in the foundling home were highly susceptible to illness and suffered a high mortality rate despite excellent hygienic conditions. The control groups in home environments and those in the nursery continued to progress within normal limits (Spitz, 1945).

Tekely and Dittemore (1978) described a case report of a four-year-old girl whose history of multiple hospitalizations, accompanied by separation from parents who rarely visited, led to both oral and anal regression. The child was hospitalized at seven months of age for failure-to-thrive (for a period of two months); at 29 months for diabetes; and at 4 years she was hospitalized for nausea, vomiting and

diarrhea. She spent 62 days in the hospital, then, after being discharged, was readmitted for 49 days with infectious diarrhea. Although she had previously demonstrated age appropriate behavior, she regressed to more infantile behaviors in her speech, feeding and play.

This case report described and analyzed the patient's regression but did not examine the biological family or parent-child relationship. A sibling had been placed in foster care and the mother was reportedly withdrawn and insecure, having been hospitalized for psychiatric care.

Zager (1980), a clinical associate professor of both pediatrics and psychiatry at Jefferson Medical College, used seven case studies to illustrate the degree of withdrawal, depression, regression, and psychopathological response to hospitalization that was evident among the children. Factors that determine a child's reaction include the relationship of the child with his family, the reason for hospitalization, the severity of stress and family response and support according to Zager's findings (1980).

In an attempt to discover psychopathology among children in a pediatric hospital, to see how often such psychopathology is diagnosed, and to see how often children are hospitalized unnecessarily, Stocking et al. (1972) studied every 20th child admitted to a pediatric hospital over a period of 10 months. Nineteen mothers and one father were interviewed by a child psychiatrist within 48 hours of their child's admission. An effort was made to identify children with personality problems or emotional response severe enough to require a psychiatric

consultation. The frequency of unnecessary hospitalization was assessed separately by a child psychologist and a pediatrician. According to the child psychologist, 5 percent of the children could have been diagnosed and treated without hospitalization, but advantages of hospitalization outweighed disadvantages, and 30 percent could have been diagnosed and treated as out-patients. The pediatrician's appraisal of the same sample revealed that 17.5 percent did not require hospitalization although it was advantageous, and in his opinion, hospitalization was unnecessary for diagnosis and treatment of 12.5 percent of the children. The researchers suggested that the parents were focusing on physical problems instead of emotional, which led the researchers to conclude that there is an unusually high incidence of emotional problems in children in hospitals even though they are not readily diagnosed (Stocking et al., 1972).

Hospitalization of children during infancy has been implicated as a risk factor in child abuse. In a study of 25 abused children who were compared with 35 siblings, six risk factors were statistically significant for abuse: abnormal pregnancy, abnormal labor or delivery, neonatal separation, other separations the first six months, and illness in the first year of the child's life. The abusive families came from multi-socioeconomic groups; more of the abused children resulted from planned pregnancies and there were no differences in sex. Forty percent of the abused children were separated from their mothers for 48 hours or more at birth. Only 2 percent of the siblings were separated. Five of the abused children were hospitalized during the first six months while one sibling was hospitalized. Sixty

percent of the abused children had acute or recurring medical problems during their first year, while only 10 percent of the siblings were seriously ill. Lynch (1976) suggested that "any continuing medical problem in the child can contribute to the process leading to abuse" (p. 51).

For seven years, Trout (1983) interviewed families with sick or handicapped children as part of his research on social attachment and breakdown in families with children from infancy to 30 months of age. He found that parents grieved for the healthy, idealized child who was "lost" to them when their newborn was found to be ill or handicapped. Parents became preoccupied with finding the cause of the medical problem as they struggled with feelings of anger, grief and despair. While hospitalization often causes behavioral and emotional reactions in healthy children, handicapped children are even more vulnerable. Often multiple hospitalizations are required in special facilities far from home. Institutionalization makes "an already difficult child even more difficult to manage, may disrupt developmental progress and hard-to-achieve family routine, and may magnify parental and sibling conflict about the place of the sick or handicapped baby in the family" (Trout, 1983, p. 343).

Starbuck, Adelson, and Hustace (1979) compared a group of 35 children, hospitalized for abuse or neglect, with 34 children who were hospitalized for accidental injuries. The population consisted of children, age 4 and under, who were hospitalized during a period of four years. Controls were matched for sex, diagnosis and socioeconomic status. Children in the control group had only new

fractures while 5 abused children had old and new fractures. All of the control group went home to their families while 18 (51.4 percent) of the abused children went into foster care. Two abused children died during their hospitalization.

Seven (20 percent) of the abused children had multiple hospitalizations during the follow-up period of the study: one was admitted three times; 1 admitted four times; 3 admitted for repeated abuse or neglect; and 4 for treatment related to the original injuries. Those children who were hospitalized for nonaccidental injuries used about ten times more community support services than the control group of children (Starbuck et al., 1979).

In summary, research of the literature supports the notion that hospitalization of children is traumatic and should be kept to a minimum (Quinton & Rutter, 1976; Stocking et al., 1972; Zager, 1980; Spitz, 1946). Studies show that in fact children are being institutionalized in hospitals, particularly when the children come from lower socioeconomic or dysfunctional families (Knitzer et al., 1978; Pill, 1977). The hospital is "probably one of the very worst homes for a child which we could construct" (Martin, 1976, p. 157).

Separation of infants from mothers has been implicated in increasing the risk of abuse and neglect as such separation severs the mother-child bond. Premature infants, for example, have a high risk of abuse (Lynch, 1976; Trout, 1983) as do children who are ill or handicapped (Trout, 1983).

There is no doubt that frequent or long-term hospitalizations can be detrimental to children and their attachment to their families. When a medical foster family "rescues" a hospitalized child who has been abused or neglected, the family will be confronted not only with the health care problems but with behavioral sequelae of abuse or neglect and long-term institutionalization. Furthermore, if biological families have turned away from the child, medical foster families will be confronted with the problem of how to emotionally reattach the child to the family.

Foster Families

Because of lack of training and overcrowding, typical foster families are not prepared to provide the daily care and evaluation of children who need tube feeding, tracheotomy care, sterile dressings, physical therapy and frequent clinic visits. Carbino (1980) found that most foster parents were not educated past high school. They were generally in their middle to late forties, predominately white, with a low to middle income. Typical foster parents own their homes, have low mobility, are married and have children of their own. They are usually defined both in research and clinically as the "foster child's parent" (Carbino, 1980, p. 5). Foster fathers have been neglected in the research as have foster families' roles as a unit, as team members and as colleagues. Carbino (1980) concluded that researchers need to study the roles of foster families "beyond that of substitute parent" (p. 33).

Hampson and Tavormina (1980) interviewed 34 foster mothers to discover the motives, rewards, regrets, and problems they experienced

as foster parents. Nineteen foster mothers were white and 15 black. As in other studies (Fanshel, 1975), the majority (65 percent) lived in rural areas, were not highly educated (mothers averaged grade 10.03 and fathers, 9.35). The average child placement lasted 3.3 years. The motives for foster parenting reported in the study were both social: love of children, desire to help, and interest in children's well-being; and individual: wanting a child to nurture, or wanting a playmate for another child. Mothers who had been foster parents for two or more years reported significantly higher social motives than did neophyte foster mothers. No one listed money as a motive, but three mentioned money as a reward.

Complaints of the 34 foster mothers centered chiefly around discipline. Hampson and Tavormina (1980), like Fanshel (1975), found the foster mothers to be the chief disciplinarian; however, 7 of the 34 mothers stated that their husbands were equally involved in child rearing. Those 7 foster mothers were from families with higher levels of education and income.

The study by Hampson and Tavormina was limited to interviews of a relatively small sample of foster mothers in a community in central Virginia. A strength of the study was that the interviewers were independent researchers, not case workers associated with an agency. While the data are not generalizable to other populations due to lack of random selection and both internal and external validity problems, the study did point out areas for further research. The researchers suggested observing foster parent/child interaction, assessing attitudes and motivations and focusing on "the therapeutic orientation and ability of foster parent applicants" (Hampson &

Tavormina, 1980, p. 112). Furthermore, they suggested that foster children be matched with parents according to the foster parents' therapeutic abilities, motivational level and the child's presenting problems. They concluded that foster parents need a more professional status and that they need to have a voice in the decision making of case management (Hampson & Tavormina, 1980).

In a study of 142 foster parents in Rhode Island, 80 percent of foster families were white, married, and with a median income of $15,000 in 1981. Their ages ranged from 36 to 60 years. These parents complained that in only 50 percent of the time did they receive necessary information regarding medical histories and case plans of foster children. About half of the families said they might be willing to keep children with handicaps, minority children or those with emotional problems; 25 percent, however, planned to leave foster care because of unexpected demanding needs of foster children, low payments and interference with their own family's well-being (Enos, 1982). The research identifies probable areas of conflict between medical foster parents and state agencies. Social service providers who view foster parents as part of the client system may be threatened by medical foster parents who exhibit assertive behavior, who make independent assessments, who intervene and evaluate their independent nursing decisions. The issue of professional status will be examined in the present study in an effort to discover how medical foster parents are seen by other professionals.

Foster Children in Need of Medical Care

The Massachusetts Governor's Commission on Adoption and Foster Care reported that almost 40 percent of foster children have some kind of disability. This rate is much higher than in the general population (Gruber, 1978). Fifteen percent of the 5,933 children in foster care who were studied had multiple disabilities (Gruber, 1978). Shah and Poulos (1974) also reported that 40 percent of the children cared for by welfare agencies in British Columbia had some kind of handicap. Severe handicaps were discovered in almost half of the children in foster care.

Twenty-seven foster children, age 4 months to 12 years, in 22 homes, were studied during a 21-year period by a Mental Development Center. Eighty-seven percent of the foster children had needs beyond usual child care with 58 percent needing special out-of-home management. Foster parents in the study had difficulty realistically accepting the children's development delays, "with 18 out of 30 partially accepting and one largely denying handicaps" (Browder, Ellis, & Neal, 1974, p. 35).

Significant positive associations were found between the foster family's ability to accept a child's handicap and their adequacy in meeting in-home and out-of-home needs, use of agencies, and positive emotional gains of the child. An inverse relation was found between the number of out-of-home activities and adequacy in meeting the needs, and likewise an inverse relation was found between the number of children in the home and meeting in-home needs (Browder et al., 1974).

In a study to examine the kinds of factors that contribute most to placement of children in foster care, 7,770 first episode reports of abuse and neglect gathered from the Central Registry of Child Abuse/Neglect in North Carolina were analyzed. Fifteen percent of the cases included foster care placement. Parental stress of the biological parents and types of abuse (burns and scalds) were found to be significant risk factors for foster care placement. At risk were children of parents who accepted the use of severe punishment, children of parents with substance abuse, children with severe injuries that required hospitalization, and children who were abandoned (Runyan, Gould, Trost, & Loda, 1981).

In an attempt to quantify needs of handicapped children in foster care, Shah and Poulos (1974) developed a questionnaire to measure the level of care needed by children in the areas of "personal care, supervision of medical care, therapeutic physical care, ancillary care and therapeutic emotional care" (Shah & Poulos, 1974, p. 32). Items were tested with 50 foster parents and 15 social workers on a randomly selected sample of 100 children. The study also compared the severity of handicap (mild, moderate, severe) to the level of care needed. Data were collected through personal interviews with foster parents and social workers at the times questionnaires were completed. Telephone interviews were also used.

Analysis of data included assessing the "degree of reliability of each rating scale individually on the basis of interjudge agreement and to assess the extent to which the two scales measured the same phenomenon" (Shah & Poulos, 1974, p. 34). Shah and Poulos

found 79 percent agreement between social workers and foster parents as to the severity of handicap, which was defined according to "frequency of remedial, social, medical or educational treatment required by the child" (Shah & Poulos, 1974, p. 33).

This instrument appears to be useful as a measurement of level of care needed by children with medical, developmental or emotional problems. However, difficulties with scoring are readily apparent. The instrument is scored by checking a statement if it applied and ranking it (1), (2), or (3). A level (1) requires no more time, energy, or skill than would be spent for a child without the problem; (2) requires a moderate amount of time, energy and skill; and (3) requires a great deal of care. Only those items that are checked and ranked are scored or summed. Consequently, the score of a child with one severe problem and a number of minor problems is reduced due to the lower rating of the minor level (1) or level (2) problems. Furthermore, since this instrument is used for determining board rates, foster parent payments could be reduced as problems are resolved. Consequently, the instrument would be punitive as goal attainment is reported.

Foster children in general are often reported to have health problems requiring out-of-home management. Medical foster children with burns, tracheotomies and the like require frequent clinic visits, daily medications, nursing care and physical therapy. They are also likely to exhibit developmental delay associated with abuse, neglect and lengthy hospitalization. This study examines the worries, unexpected situations and disruptions of family systems that are

associated with the problem of such children. The study explores both the stresses and thn coping strategies of medical foster parents as they attend to foster children in need of extensive medical are and supervision.

Fostering Process

The literature provided evidence that the foster parenting experience produces emotional strain on families. Littner (1978), the Director of the Child Therapy Program at the Chicago Institute for Psychoanalysis, cautioned that foster parents because of their own childhood and life experiences bring an emotional equilibrium to the foster care experience that is based on their repertoire of coping abilities. Through case studies, he illustrated that those foster parents who have unresolved conflicts due to previous losses may be prone to experience acute separation anxieties when foster children return to biological parents. Foster parents need the satisfaction of meeting expectations, but children often set up barriers that are difficult to penetrate. Foster children may be unresponsive, provocative, withdrawn, and manipulative. Biological parents are often resented. especially when they are difficult, uncooperative and unpredictable. Visits by the biological parents typically precipitate disruptive behavior in children, and foster children are apt to play one set of parents against the other. Foster parents sometimes seem unsure as to how close their relationship with a child should be; they want to be loving parents but are afraid of being hurt when the child returns home. This ambivalence may prevent such parents from investing themselves

fully in the relationship. Introducing a foster child into the home disrupts the balance and adds to problems already existing in the family.

Littner (1978) pointed out the need for a support system for foster parents. These parents need to be made aware of problems inherent in foster parenting and feel safe in discussing feelings with agency professionals. Meeting with other foster families also offers a support system.

Wilkes (1974) described stresses that foster parents may face such as the disruption of family equilibrium resulting from the additional numbers of relationships. Biological children feel abandoned due to the attention focused on the foster child; these children feel pressures to accept the foster child and guilt over hostile feelings. Family patterns such as meal time, television viewing and visits with family and friends are also disrupted. Foster families must cope with a child in transition, one who will not be there permanently, and who harbors unknown areas in his life experiences. Wilkes also noted that when the length of placement is vague, families have difficulty knowing how intimate or distant the relationship will be. Foster parents are unsure how much to discipline a child who will be going back to others in the near future. Dealing with agencies and harboring unrealistic expectations are also stresses for foster parents.

Successful coping is enhanced through open communication, awareness and understanding, feeling less threatened with the transition, gaining respect for the agency and setting realistic goals. Wilkes suggested making thorough foster home studies, taking

time to plan for a child's arrival, dealing with feelings, and making use of honest communication between the case worker and foster family. When possible, the length of foster care placement should be determined and foster parents included in the decision making.

Barsh et al. (1983) pointed out that foster parents of children with handicapping conditions have the same kinds of problems with such children as do biological parents. They cannot find babysitters; transportation for frequent clinic visits is a problem; management of disruptive behavior is stressful; and foster families become isolated and experience burn-out. Handicapped children tend to remain longer than other children in foster care and they are subjected to more foster care placements. A program called Foster Extended Family (FEF) was designed to strengthen the support of foster families with children age six or less who had severe medical problems and were in danger of institutionalization. Friends, neighbors, relatives and community members were recruited to provide respite care, transportation, help with therapy in the home, special equipment and babysitting. Members of FEF received 30 hours of training plus instruction in first aid and cardiopulmonary resuscitation. They were given payment for completing the sessions plus mileage and child care. The project also provided specialized training for foster parents, including crisis intervention. As a result of this project, foster families expressed more satisfaction in their role and increased abilities. Foster children received more attention and therapy in the home. The extended family gained satisfaction in their role and strengthened the bonds with the foster family.

McCubbin et al. (1983) studied 100 biological families who had a child with cystic fibrosis to see if there are coping patterns used by parents "to manage family life successfully when a child member has a chronic illness" (p. 359). Using the Coping Health Inventory for Parents (CHIP) they analyzed behaviors that were grouped into three coping patterns: maintaining family integration, having a secure sense of self, and understanding the medical status of the child. Data were also collected through questionnaires that examined parents' perceptions of the family psychosocial environment using the Moss Family Environment Scale (FES). Subscales that focused on family functioning were used: family interpersonal relationship dimensions, family personal growth dimensions, and system maintenance dimensions of organization and control. The findings showed that mothers' coping behaviors that focused on family integration were associated with family cohesiveness on the FES; those related to self-esteem were correlated with family expressiveness; and coping with medical information also showed a correlation with family cohesiveness on the FES. The father's family interpersonal relationships were positively associated with cohesiveness and inversely related to conflict. The mother's coping behaviors that helped maintain self-esteem and emotional stability were inversely related to the child's age. Thus, the older the child, the more coping behaviors were needed by mothers in order to maintain support and emotional strength. Fathers' coping behaviors used to maintain the family integration were positively related to family income. And fathers' attempts to understand the medical situation were correlated with both income and age of the child.

Therefore, the fathers with higher income worked harder to keep family integration intact and to understand and be involved with the medical care of the child.

The researchers concluded that professionals need to help parents of a child with a chronic illness strengthen their coping before conflict and major problems erupt. Families in this study that were at a higher risk for total family disruption were single parents, families whose chronically ill child was older, and families with lower incomes (McCubbin et al., 1983).

One of the strengths of the study is that the researchers looked at coping mechanisms of parents rather than focusing only on the difficulties of having a child with multiple health problems. The sociodemographic profile of the population studied by McCubbin et al. is similar to the medical foster families in this study. The population in McCubbin's study had higher average incomes and were better educated than typical foster families. Twenty percent of the mothers and 25 percent of the fathers had college degrees. The study described coping patterns that may appear in the qualitative data from research on medical foster families' coping.

In a boarding home arrangement for handicapped children who had to leave their own school district for special classes, a concept of co-parenting evolved. Between 1970 and 1978, 250 handicapped children were voluntarily placed in boarding homes near the school. Co-parenting was useful for more than 25 percent of the children. The process of relationship building occurred

with "defining the territory; natural parents' emotional dependency on the boarding home parents; and joint decision making and mutual support" (Berkin, 1979, p. 11). Biological parents and boarding home parents had to go through a process of role definition as they worked through the ownership of individual and shared responsibilities. Commonalities among the 68 families were observed. Biological parents were able at first to carry out the prescribed programs for their children, but were later brought to the attention of welfare agencies as "unresponsive, apathetic or angry" (Berkin, 1979, p. 12). These families felt the handicap interfered with family and sibling needs. When families were faced with a crisis, child care declined to the point of neglect. Co-parenting offered situational support and relief from total responsibility of the child's care, thus allowing families time to meet some of their own needs.

An area of difficulty with which foster families must cope occurs when foster children return to their biological parents. Foster parents are expected by agency experts to "separate gracefully" from their foster children after they have brought children, suffering from abuse or neglect, into their homes, nursed them back to health, fostered their social development and loved and cared for them for a year or more (Edelstein, 1981). Biological parents can prepare for their children to leave home as they reach adulthood, but foster parents must deal with separation without the satisfaction of completing a parenting role. Furthermore, they have no socially sanctioned mechanism for expressing the grief they

experience on the departure of their foster child. Edelstein (1981) stated that grieving must be shared in order to resolve feelings effectively; therefore, foster parents need support in grief work. Barriers to effective grief occur when relationships are ambivalent. When foster children have been difficult, foster parents may feel relief at not having to deal with acting-out behaviors. Foster parents represent a part of the child's past that biological parents may wish to forget once their children are returned to them. But lack of communication and follow up "can only increase the foster parents' pain at a time they are most vulnerable. . ." (Edelstein, 1981, p. 469).

The demanding parenting roles of these families permit little time for grief work, especially if a case worker brings a new foster child into the home as soon as one has left. Foster parents are warned not to get too close to a foster child; therefore, grieving the loss of a child may imply that foster families were amiss in their role. Finally, foster mothers may avoid feeling dependent and helpless while grieving, as they are used to a role of nurturing and taking care of others. Edelstein (1981) suggested that open communication, social and educational programs and self-help groups be used to help foster parents with grief.

Medical foster parents are asked to bring an abused or neglected child from the hospital into the home; they are expected to nurture, love and nurse the child back to health--then return the child to its biological family. This process is predicted to produce stress and necessitate conflict resolution as medical foster parents move through the phases of the fostering process.

The study examines behaviors of medical foster families as they disengage themselves both physically and emotionally from children who return to their biological families or another foster home placement.

Role Ambiguity

Lack of definition of the foster parenting role has led to role ambiguity and role conflict. Foster parents are defined by others as "a client, a staff member, a natural parent, a volunteer, 'professional parent,' or unclassifiable" (Glickman, 1981, p. 385-A). In a study of role ambiguity based on role theory, relationships were explored among "foster parents' role perceptions, demographics, foster parenting experience, and difficulties in role performance" (Glickman, 1981, p. 385-A). A survey questionnaire was mailed to 427 foster parents. Ten foster parents who were volunteers from a training program and their caseworkers were also interviewed. Findings indicated that foster parents were ambiguous over their role perception. Demographic variables did not offer any explanation for the differences. Experience contributed to a desire for pay--those parents with more experience were more likely to request extra payment. Foster parents were inconsistent in understanding of their roles and found foster parenting more difficult than expected (Glickman, 1981).

Carbino also cited role ambiguity. In foster parent training programs, there is a focus on "mutual roles, teamwork and the specialized roles of the foster parent," but research continues to define foster parents as parents rather than colleagues of other professionals (Carbino, 1980, p. 6).

In an exploratory-descriptive study of 40 children, biological parents, foster parents and workers, Kufeldt (1983) also found role ambiguity among foster parents. Perceptions of the reasons for foster care placement were incongruent; children endured multiple placements, and were often adrift in the foster care system. After three years, 30 percent of the children were still in care. Contacts with biological parents were infrequent. The implications of this study included the need for role clarification and the need to include biological parents in the care of their children. The need for support services for dysfunctional families and the importance of early permanent planning to prevent drift were both stressed. This study offered theoretical perspectives and pointed out needed services but did not offer in-depth analysis of what occurred in the fostering process with the children in care.

Medical foster parents are expected to function in multiple roles of nurse, parent, spouse, educator and advocate of biological families. As professional nurses, they should be treated by medical and social agency experts in an egalitarian manner. Role ambiguity and lack of professional recognition continue to be areas of conflict for medical foster families who are not given professional recognition by the medical community or other professionals; instead they are seen as parents.

Visitation with Biological Families

The importance of biological parents to children in care has been well documented. Bowlby (1961) studied healthy children age 2 and age 3 who were left in residential nurseries and not

visited by their mothers. Children went through a sequence of protest, despair and detachment. When the mothers returned, the children continued to remain unresponsive for several days prior to reattachment. Littner (1975) found that children do not understand why parents place them in foster care; children miss their parents and idealize them unrealistically. Children identify with their parents and criticism of biological parents is perceived by the child as criticism of him. Littner suggested contracting with biological parents to promote visitation of children while in out-of-home care. Visitation helps children see biological families more realistically and helps allay separation fears. Visitation keeps family relationships intact so that the child is not a stranger when he returns home.

In a study of 60 foster children, a positive relationship was found between the outcome of treatment plans and whether or not biological parents signed a contract which included visitation schedules. Sixty-seven percent of parents who signed the contract were successful in regaining their children. The researchers concluded that biological parents' willingness to sign performance agreements can be a useful indication of participation in the treatment plan (Stein, Gambrille, & Wiltse, 1977). This study may be guilty of making complex issues too simplistic in attempting to demonstrate cause and effect. Contracting is useful for forcing parents to comply with treatment but may not explain fully the changes in behavior that enable parents to regain custody of their children.

Fanshel (1975) followed 624 children in foster care for five years. The children ranged in age from infancy to 12 years. At the end of five years, 36 percent of the children were still in care; 56 percent, discharged; 5 percent, adopted; and 3 percent, in mental institutions or training schools for delinquents. Those children who were placed in foster care due to neglect or abuse received few visits. A strong association was found between the frequency of visits and the discharge of children to their homes. At the end of five years, 57 percent of children still in care were not being visited.

Medical foster families are expected to invite biological parents into their homes on a regular basis. This study explores feelings, conflicts and cultural differences that influence the success of in-home visitation.

Foster Parents as Role Models

Medical foster parents are expected to use role modeling as a teaching method to improve parenting skills of biological parents. Davis and Bland (1978) reported success in using foster parents as role models for biological parents. The goal of intervention was to return children, ages 3 to 10 years, to their homes within a year. Contracts were used to commit foster parents, biological families and social workers to the time limited treatment plan. Four stages evolved as relationships developed. At Stage One, there was an atmosphere of competitiveness, hostility, mistrust and fear. The social worker's energy was directed toward helping both foster parents and biological parents

share feelings. Foster parents needed support to prevent counter-attack; biological parents needed to feel that their anger was recognized, but that they were accepted as caring individuals. During this phase, foster parents asked biological parents about their child's habits such as bedtime rituals, play or food preferences. This process enabled foster parents to "model the role of learner, saying, 'It's okay not to know'"(Davis & Bland, 1978, p. 383).

At Stage Two, foster parents began teaching parenting skills and emphasized biological parents' strengths. Many biological parents began to test the limits of their contracts by being late or absent for visits. By Stage Three, the social worker's role was minimal as foster parents became the primary role models. Davis and Bland (1978) found, "a corrective emotional experience usually occurs through the parents' identification with foster parents" (p. 382). Stage Four was the separation and termination phase. The foster parents' task was to role model separation without rejecting the biological parents. Davis and Bland concluded, "The use of foster parents as teachers of parenting behavior is a powerful resource that can develop and strengthen the child management skills of parents" (1978, p. 386).

Foster parents who demonstrate concern and advocacy for biological parents can increase the self-esteem of dysfunctional families and reinforce their efforts to improve their lives in order to achieve the return of the child. Foster families can

model specific behaviors, appropriate parenting skills, interpersonal skills and use of community resources. They offer a nurturing environment and through close interaction with biological families can offer a "more consistent emotional environment for the child" (Ryan, McFadden, & Warren, 1981, pp. 189-190).

Gagne (1979) pointed out that in order for role modeling to be successful, the model must establish credibility and be appealing. Foster parents who can accept a role of professional responsibility are needed.

Medical foster parents have the potential for using role modeling as an effective instructional tool. Research that explores the behaviors that enhance this condition of learning will add to the knowledge of parent-to-parent interaction.

Predicting Success

Polansky, Chalmers, Buttenweiser and Williams (1980) studied neglectful families in Appalachia and later replicated the study with 46 neglected families in Philadelphia. Polansky et al. concluded that foster care placement of children is more successful when biological parents are in agreement with the decision. Many neglectful parents are unable to accept their parenting role and thus experience relief with the temporary removal of their child.

In a study to examine foster placement failures and to discover factors that might lead to success, Stone and Stone (1983) examined 64 records selected from three welfare units in

a mixed urban-rural area of the Southwest. The dependent variable was the outcome of placement. A successful outcome was defined as continued placement for not less than 60 days. Failure included removal of a child within 1.5 years of placement because of the child's behavior or noncompliance by the biological family. To further assess the cases, a questionnaire was used that grouped 63 variables into characteristics of the agency, the biological family, the foster children and the foster parents. Assessment scales included the Potential for Foster Parenthood Scale (PFP), the Missouri Children's Behavior Checklist, and the Global Assessment Scale for determining the mental status of biological parents. Inter-rater reliability for these scales was determined by pilot studies and a score of .75 or greater was necessary for acceptance.

Of the 64 cases examined, 48.5 percent of children were withdrawn from foster homes due to disruptive behavior. Eleven of the 63 assessment variables were significantly associated with the outcome of placement: (a) the contact, rapport and energy spent by the caseworker with foster parents; (b) the rapport between foster parents and the agency; (c) competency of foster parents according to the PFP; (d) motivation of the foster mother; (e) opportunities for intellectual development of foster parents; (f) good school conduct of the child; (g) socialization of the child; (h) absence of aggressive behavior; (i) normal attachment and separation behavior by the child; (j) rapport between the foster child and caseworker; and

(k) foster placement precipitated by acute rather than chronic family problems. Multiple regression analysis (stepwise) generated three predictor variables: overall rapport of foster parent with the agency, the child's school conduct, and chronicity of the problem that precipitated foster care placement.

In this study, nearly half of the children were removed from foster care placement and most of the incidents occurred within four years after placement. Stone and Stone (1983) concluded that "highly competent, emotionally healthy foster parents need to be recruited" (p. 16). Cross validation studies are needed to add to the prediction of successful placements. Different populations of foster families and children may produce different scores of predictors; however, as Stone and Stone (1983) pointed out, this study is "a pioneer effort in the area of 'predicting the outcome of foster placements by statistical means'" (p. 16).

Olsen (1982) explored the relationship between children's individual characteristics and foster care outcomes. Using stratification theory, Olsen developed a causal model to test the relationship between 16 variables, foster care placements and length of stay. "Exploratory, descriptive and explanatory research strategies were used during different stages of the study's development" (Olsen, 1982, p. 10). Independent variables were race, age and handicap. The study explored a population of 566 children who were not expected to return to their biological parents. Two-thirds of the population was white, one-third

minority; one-third had emotional and social problems, and one-fourth had mental handicaps. One out of 10 children had physical handicaps. The mean age was 10 years 3 months, and over half were in foster care due to neglect.

Olsen found that half of the children had been in care 17 months or longer between foster care placement and severance of parental rights and 8 months or more between permanent custody by an agency and placement in an adoptive home. Half of the children were in care for 3.5 years or longer; half of those not in permanent custody had been in care 4.5 years or longer. Children averaged 3 placements while in foster care. After 18 months, two-thirds of the population remained in long-term foster care and one-third went into adoptive homes. Analysis of the variables showed that agencies planned for long-term foster care rather than adoption for children age 8 and older. From initial placement to permanent custody, age, physical handicap, reason for care and race were important variables. Children with a handicap and children placed in foster care due to neglect spent an average of one year longer in care (Olsen, 1982).

From the time the agency received permanent custody (with severance of parental rights) to the point that children were placed with adoptive families, age and race were strong indicators. Social-emotional handicaps and physical handicaps were weaker determinants. Older children, minority and those with handicaps all spent one to two years longer from the period of permanent custody to placement with adoptive families.

Olsen's research "demonstrated the usefulness of stratification theory in examining the experiences of children in foster care" (Olsen, 1982, p. 18). The research contributed to theory and generated implications for policy and further research. Age is a discriminator in terms of foster care outcomes as are race, emotional problems and physical handicaps. While this study attempted to quantify cause and effect and was successful in accounting for up to 60 percent of the variance that contributed to foster care outcomes, the study did not attend to the process or human experience on a subjective level.

The research (Stone & Stone, 1983; Olsen, 1982) points to variables that are associated with success of foster care placement. Some of these variables have been met by the medical foster care program. One specific foster care case-worker is assigned to medical foster care case management. There are no other families in that caseload. This arrangement allows for frequent interpersonal contact, effective use of energy and the building of good working relationships between the foster care case manager and medical foster families.

Stone and Stone (1983) stressed the need for highly competent foster parents. Medical foster parents go through foster parent training and submit to a home study prior to licensure. One parent in each family has a background in nursing education and clinical experience. These families have the potential for being highly competent.

The literature suggested that variables such as race and age preference be considered when foster parents are asked to

take a child. The study explores attachment and distancing behaviors of medical foster parents and children in an effort to discover how variables such as age, race or health problems influence attachment and how they relate to successful foster care placement.

Implications of the Literature Review

A review of the literature showed that institutionalization of children in hospitals is detrimental to their physical and psychosocial development. Children who are discharged from hospitals into the homes of medical foster families are likely to exhibit behaviors associated with recent hospitalization. The present study explores the effects of bringing previously hospitalized children with severe health problems into foster family settings. The literature suggested that foster families need the satisfaction of fulfilling their expectations, but that foster children may be unresponsive, manipulative, provocative and withdrawn.

The literature suggests a caveat that foster parents of children with handicapping conditions need support and understanding; otherwise, they are at risk of isolation and burnout. Children who are placed in medical foster care pose problems similar to children with handicapping conditions. Because of medical problems, the study population of children with burns, tracheotomies or chronic lung conditions cannot be left with teenage baby sitters; they require daily nursing care and need

transportation for frequent medical appointments. The study examines such stresses and strategies for dealing with them.

The review of literature also uncovered the difficulty foster parents experience when they return children to biological families. The goal of medical foster care is reunification of children with their biological families. Behaviors of foster families during the transition and detachment phase are described in this study.

The literature identified role ambiguity as an issue to be recognized. In this study, ethnographic questions uncovered similar ambiguities that medical foster parents experience in relationships with other professionals.

Family visitation was identified as a variable that was associated with the return of foster children to their own families. Medical foster families are expected to invite biological parents with different values, educational and socioeconomic status and different lifestyles into their homes. Problems inherent in home visitation are explored through this ethnographic study.

The review of research has supported both the need for medical foster care and the need for qualitative research that aids in understanding the experience from the view of the medical foster families themselves.

CHAPTER III

METHODOLOGY

This ethnographic study was designed to ascertain what is involved in the process of becoming a medical foster parent. Ethnographic methodology was selected as the research strategy because of the nature of the problem under study. Medical foster care is a newly designed program for abused and neglected children with severe health problems. The purpose of the study was to learn what was going on in the lives of the families with medical foster children; what the foster parenting experience was like; and whether foster parents could provide nursing care and nurturance and at the same time act as effective role models for biological parents. Medical foster families have a culture of their own which needs to be understood.

Ethnography is a research method used to uncover a way of life or culture from the viewpoint of the participants. Spradley (1980) defined culture as "the acquired knowledge people use to interpret experience and generate behavior" (p. 6). Ethnographic research explores human experience through the study of behavior, knowledge and cultural artifacts. This research employs the theoretical framework of symbolic interactionism, a theory which presupposes that individuals react to things according to

perceived meanings and that meanings are constructed in the process of human interaction (Blumer, 1969). Both explicit and tacit knowledge of medical foster parents were sought out in the research process through interviews and observations.

Research Procedures

Participant Observation

Participant observation is frequently associated with this qualitative research methodology. "The participant observer comes to a social situation . . . (a) to engage in activities appropriate to the situation and (2) to observe the activities, people and physical aspects of the situation" (Spradley, 1980, p. 54). Ethnographers participate in social situations to some degree and also observe the situation from the perspective of an outsider. Participant observers keep detailed fieldnotes of subjective feelings and objective feelings. The degree of participation exists along a continuum of no involvement, to a "spectator" role, moderate participation, active participation, and finally to complete involvement. My participation with medical foster care would be labeled "moderate" which is defined as maintaining a balance between participation and observation (Spradley, 1980).

The participant observation model used in this study followed Spradley's (1980) Developmental Research Sequence (DRS). This model uses sequential tasks that begin with asking questions,

collecting and recording ethnographic data and analyzing the data to discover new questions to be asked. The acts of participant observation and recording of fieldnotes are always followed by analysis of data, asking new questions, collecting more data, writing more fieldnotes and analyzing the findings. This cycle continues throughout the study. The researcher first makes broad descriptive observations of the social situation and begins the initial data analysis. The study is gradually narrowed through focused and selective observations.

The Setting

Since 1980, I have worked closely with medical foster parents through my role as a nurse consultant to the Children's Crisis Center. I was instrumental in developing the pilot project, recruiting nurses, writing a Federal Grant for program expansion, training and research. One of my tasks was to develop an instrument to determine the level-of-care needed by abused or neglected children with acute health problems. The instrument was used to aid in the determination of children's suitability for the medical foster care program and to determine the amount of monthly payment to medical foster parents. Field experience included participation in preplacement staffing of all the children who were placed in medical foster care, attending eight court hearings, observing clinic visits and consulting with professional staff both in hospitals and the system of Health and Rehabilitative Services (HRS). In an effort to expand my knowledge of foster care, I went through six weeks of HRS foster parent training which

consisted of weekly sessions lasting about three hours each. During the study I made more than 30 home visits to medical foster families that lasted from one to five hours. I accumulated almost 200 pages of typed fieldnotes. For a six month period, 20 hours per week were spent in the field or at the Children's Crisis Center attending to the needs of medical foster families, children in care and working along-side case coordinators, the foster care case manager, the project coordinator and the project director. Thus, I was in the mainstream of the program as an "insider-outsider." That is, I was inside the medical foster care system and worked as a participant observer. My interaction with medical foster parents and other members of the foster care system allowed me to directly observe situations and events related to medical foster care in their natural settings (Schatzman & Strauss, 1973).

Sample Population

From the summer of 1980 until the fall of 1983, five families participated in a pilot medical foster care program. In the fall of 1983, a Federal Grant from the Department of Health and Human Services made it possible to expand the medical foster care program. To date, seven abused or neglected children have been placed in medical foster care. The sample population of this study consisted of the five families in the pilot program and three additional families who took part in the program from the fall of 1983. One child lived in a medical foster home for almost 11 months before returning home to her biological family. She was later placed in

a second medical foster home where she stayed for two more years. All eight medical foster families agreed to participate in the study. When data collection began, the subjects had had medical foster children in their homes from 3 weeks to 23 months.

Three medical foster families had taken care of children until they regained their health and sent them back to biological families or to a regular foster care placement. Four other families still had children in their care at the time of the study. All the medical foster families were licensed by the Department of Health and Rehabilitative Services (HRS) and included a registered nurse as a primary caretaker. All families agreed to work closely with biological parents to protect the parent/child attachment and to help biological parents improve their parenting skills.

The sample size was small, but it included all the medical foster families in the program from its inception to the time of data collection. The question might be raised whether eight families constitute a population large enough for this study. Certainly, if there had been 15 or 20 more families, one might feel more secure; on the other hand, commonalities were found across families. Informants were interviewed at different times in the fostering process and they related similar experiences. A saturation point was reached when data analysis did not produce new information. "The criterion for judging when to stop sampling the different groups pertinent to a category is the category's theoretical saturation" (Glaser &

Strauss, 1967, p. 61). The sample of eight families was adequate to discover meaningful patterns in the socially constructed world of medical foster families and to explore their "taken for granted" definitions of reality. Due to the participants' continuous participation in the medical foster care program, patterns of behavior emerged that yielded domains, concepts and themes for analysis as medical foster parents confronted, interpreted, and reacted to situations they encountered (Blumer, 1969). As I continued to find similar instances over and over, I was "empirically confident" that the categories of data were saturated (Glaser & Strauss, 1967).

Data Collection

Ethnographic data were gathered in fieldnotes, transcribed interviews, videotapes of medical foster parents and their foster children, tape recordings of medical foster parent meetings and notes from court hearings. Because of my unique position as a consultant to the Children's Crisis Center (CCC), I had ready entry into the medical foster family environments before the study began. I gained permission of both the CCC and medical foster families to enter the setting for the specific purpose of conducting research. Court records, case files and foster home studies were all put at my disposal. As a result of my previous interaction with the medical foster families, we had begun to establish trusting relationships. I was concerned that informants might consider me a part of the CCC and therefore be reluctant to share information fully and

honestly. I made it clear that I was no longer in a decision making position; I visited and listened and had empathic relationships with them. We dealt with some issues that they felt were important. I was not only observing but was drawing from them and discovering the process as it unfolded. Medical foster families were willing to permit me to explore not only their public but also their private space as I inquired into their "world, thoughts and feelings" (Hutchinson, 1983, p. 9).

In an effort to systematize the data collection, I set up appointments and interviewed each of the families in their homes using the guiding question--What is involved in the process of becoming a medical foster parent? The preliminary questions that explored roles, relationships, phases of the experience, stresses and coping behaviors were asked during open-ended interviewing. Subsequent informal interviews and telephone conversations were used to add new data, to ask new questions that were generated out of data analysis and to validate inferences, themes and patterns that emerged during the research process. Three group meetings of medical foster parents were included in the data collection. Interviews and group meetings were audiotaped and then transcribed by me in order to facilitate systematic analysis.

Observations were descriptive, focused and selective--ranging from a broad overview to a narrow focus. Data were analyzed in a cyclical fashion to discover new problems and questions to be asked (Spradley, 1980). Formal data

collection and analysis ran from September 1983 through April 1984.

Threats to Validity

Members of a given culture are assumed to be carriers of that culture and can be considered potential informants with face validity (Brink & Wood, 1978). Medical foster parents were considered members of a given culture by virtue of their common experiences with abused and neglected children, with social agencies, courts and with one another. They constituted a population that shared certain characteristics, behaviors, roles and definitions of reality. Each family included a nurse as a primary caretaker. Each family assumed the responsibility for foster parenting an abused/neglected child with acute health problems. And each family worked closely with biological parents to promote reunification of children with their biological parents. As a group, these medical foster families carried on the culture of foster parenting.

Some of the families had returned medical foster children to their biological parents or another placement and no longer had children in their care at the time of data collection. Since these informants no longer had a vested interest in presenting information from a particular viewpoint, their responses were expected to accurately reflect their perceptions.

Informants were reassured that fieldnotes would be kept confidential and that data were grouped for themes and patterns.

Identities of foster parents and medical foster children were protected through the use of pseudonyms and code numbers. I reassured the participants in writing, verbally, and through my behavior over time that my role was primarily that of a researcher and my purpose was to listen and attempt to understand their medical foster parenting experiences.

One method ethnographers use for dealing with threats to validity is the process of constant comparative analysis. Information reported by informants was compared to informants' behavior in various settings, to information from other informants, and to information reported by members of the Children's Crisis Center. My participant observer position allowed me to experience the medical foster care process and to investigate first hand the activities, conflicts and decisions involved in the medical foster parenting process (Hutchinson, 1983).

I kept a journal that included my impressions, research problems, and ideas. Both objective and subjective data were recorded since introspection and self-monitoring also help identify and minimize personal bias that might influence the validity of the data (Spradley, 1980). At the end of the data collection, I met with a group of four medical foster families and discussed my findings. They responded by saying, "Yes, that was right, that was how it felt; that was the way it happened." They verified the finding that nursing care was readily routinized; attending to discipline, psychosocial

development and problems with biological parents was a more difficult aspects of the fostering process.

Ethical Principles

Ethnographers have an ethical responsibility to adhere to the Principles of Professional Responsibility adopted by the American Anthropological Association which insist that the researcher consider informants first; safeguard their rights, interests and sensitivities; communicate research objectives to the informants; protect their anonymity; never exploit the informants for personal gain; and make research findings available to the population studied (Spradley, 1980). Because of my position with the Children's Crisis Center (CCC), I had access to privileged information from the courts, from the Foster Care Unit of HRS and from entering the environment of families who were part of the project. In an effort to protect the anonymity of medical foster families, fieldnotes were kept confidential and not made available to other professionals in the Children's Crisis Center, the Department of HRS, or other informants. Pseudonyms or code numbers were used in fieldnotes and in all publications.

In an effort to safeguard the rights of medical foster families, the aims of the research were explained both verbally and in writing. I explained my desire to understand from their viewpoint the process involved in foster parenting abused and neglected children with acute health problems. They were

told that the research would aid in discovering the complexity of this treatment modality and might generate hypotheses for future research. There were no perceived risks to the informants (see Appendix). Informants were told that their participation was voluntary and that they could withdraw at any time without jeopardizing their role as medical foster parents. I was concerned that the discussion of difficult moments in the experience of foster parents might reawaken painful memories. I discussed this possibility with them. In fact, however, foster parents reported that they experienced a sense of relief when given the opportunity to share their feelings with an informed, though nonjudgmental, listener.

Other ethical problems could have evolved because of my background and socialization as a psychiatric nurse and educator. As a participant observer, I guarded against taking on the role of a counselor or an instructor but instead asked questions, observed and documented rather than advised.

Data Analysis

Ethnographic data analysis involves a thought process that requires "the systematic examination of something to determine its parts, the relationship among the parts, and the relationship to the whole" (Spradley, 1980, p. 85). Ethnographers must be aware that human activity is carried out through an interpretative process (Blumer, 1969). Thus, ethnographic analysis is a process of both description and interpretation.

If a study is to possess explanatory power, analysis of data must be well grounded in a theoretical field. Symbolic interactions provided the theoretical framework for the study of medical foster care (Blumer, 1969).

Spradley's (1980) Developmental Research Sequence (DRS) was used as a guide for data analysis. The DRS model organizes data analysis into sequential steps of domain analysis, taxonomic analysis, componential analysis, and theme analysis. Each of these steps was carried out in this study.

The first step in ethnographic analysis was domain analysis that was begun soon after systematic data collection was initiated. I examined the fieldnotes to discover cultural domains or "categories of meaning" imbedded in the data (Spradley, 1980, p. 88). Such categories were found by asking what kinds of activities, feelings, goals, relationships, and time were involved in the process of medical foster parenting. Domains that described semantic relationships such as cause and effect, rationale, attribution and sequence of events were organized according to cover terms, included terms and semantic relationships (see Table 1). A frequently used semantic relationship is what Spradley (1980) calls strict inclusion. This relationship takes the form: x is a kind of y. For example: mother, spouse, foster parent, colleague, playmate, friend, social worker, parent advocate--were kinds of roles medical foster parents assumed. Structural questions that focused the data consisted of the following: What are the things foster parents do in each role? What are the problems in each role? and What are the reasons for behaviors in each role?

Table 1

DOMAIN ANALYSIS

1. Semantic Relationship Rationale

2. Form X is a reason for doing Y

Included Terms	Semantic Relationship	Cover Term
Not the biological parent. Did not want to replace the biological parents. Wanted the child to go back. Different race. Child does not respond like a "normal child." Belief that child belongs with aunt. Knowledge that it was not a lifetime commitment.	is a reason for →	holding back

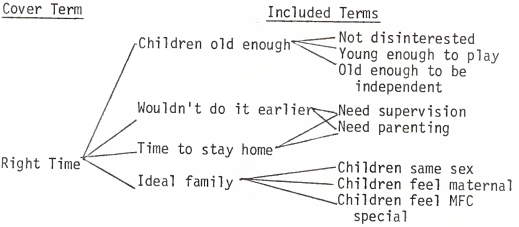
Taxonomic analysis shows relationships among the terms in a domain and how the terms relate to the whole. Taxonomies have two or more levels and are developed in steps leading from the selection of a domain to finding similarities based on a semantic relationship, looking for additional included terms, searching for larger more inclusive domains and finally constructing a tentative diagram (see Table 2).

Componential analysis, the next step, involves a systematic search for contrasting units of meaning. Componential analysis is a sequential process of identifying contrasts that have binary values and combining dimensions of contrast into units

that have multiple values. The researcher prepares contrast questions and makes selective observations to discover missing attributes and information. A componential analysis requires the validation of information through questions and participant observation. In this study, "Places to Receive Role Recognition" were entered into a paradigm worksheet (see Table 3) in an effort to disclose where and in what situations the multiple roles of medical foster parents were given recognition.

Table 2

TAXONOMY OF RIGHT TIME FOR MEDICAL FOSTER PARENTING



Ethnographic data analysis takes place at two levels simultaneously. This process consists of an in-depth analysis of domains at one level and at the same time "it will include an overview of the cultural scene and statements that convey a sense of the whole" (Spradley, 1980, p. 140). Cultural themes

apply to multiple situations and recur in more than one domain. Routinization was a cultural theme that was found in this study of medical foster parenting. Routinization occurred in the nursing care of medical foster children, in the socialization of children into the medical foster family systems and in the coordination of frequent medical appointments and hospital admissions required by the children.

Table 3

COMPONENTIAL ANALYSIS:
PLACES TO RECEIVE ROLE RECOGNITION

Contrast Set	Dimensions of Contrast			
	CCC	HRS	Hospitals	Biological Families
Mother	Yes	Yes	Yes	Yes
Spouse	Yes	Yes	No	Yes
Foster Parent	Yes	Yes	Yes	Yes
Nurse	Yes	Yes	No	Yes
Colleague	Yes	Yes/No	No	No
Biological Parent Advocate	Yes	Yes	Yes/No	Yes/No
Complainer	Yes	Yes	Yes	No

In summary, analysis consisted of examining slices of data to identify small details and at the same time keeping a holistic view in an effort to find cultural themes.

Spradley's (1980) DRS model guided the analysis of this ethnographic study through a cyclical process that was initiated soon after data collection began and continued until the study was completed.

Summary

Ethnography was selected for this study because it "yields empirical data about the lives of people in specific situations" (Spradley, 1980, p. 16). Medical foster families share a specific set of cultural knowledge and behaviors that needed exploring in an effort to understand and improve the foster care experience.

Through participant observation and interviews, data were collected using the Developmental Research Sequence (DRS). The DRS sequence is a problem-solving approach that guided both data collection and analysis. Data were collected from all the medical foster families who participated in the program. The data collection/analysis cycle was continued over an eight month period until data analysis failed to produce new categories of information.

Constant comparative analysis and self-monitoring were used to reduce personal bias. I am convinced of my success in maintaining objectivity and in communicating to informants that their views were acceptable and important (Schatzman & Strauss, 1973, p. 74). Because of my own socialization as a psychiatric nurse educator, I am comfortable with the open-ended method of interviewing used by ethnographers. The informants willingly invited me into their homes and freely communicated their thoughts, feelings and frustrations associated with medical foster parenting.

The rights and privacy of medical foster families were protected through the use of pseudonyms and code numbers. Data were intentionally grouped according to domains, taxonomies and cultural themes rather than according to individual family responses. This technique added power to the data analysis and served to futher protect the anonymity of the informants.

Analysis of data took place on two levels simultaneously. This process afforded an in-depth analysis of specific domains and at the same time produced an overview of the medical foster care experience.

CHAPTER IV

THE FINDINGS

I really learned that love is a decision.

--Quote from a medical foster parent

This ethnographic study traced the behaviors, feelings and needs of eight medical foster families while they provided nursing care and parenting to abused and neglected children with significant health problems and worked with the foster children's biological families to teach appropriate parenting behaviors. Data analysis revealed stages in the medical foster parenting experience and uncovered tacit rules of behavior that foster families learned but seldom openly discussed. In an effort to describe the experience and to decode "the cultural meaning system operating in the social situation" of medical foster care, each of the stages and patterns of behavior within each stage will be discussed" (Spradley, 1980, p. 161).

Patterns of anticipation, based on pragmatic, noble, and religious intentions, were followed by phases of turmoil, guilt and isolation as medical foster parents confronted their existential definitions of the situation. In time, routinization was established and medical foster families redefined the situation as children grew more healthy both physically and emotionally.

Medical foster families were forced to confront the reality of biological families afresh as they made plans to return the children to their care. Medical foster parents experienced existential contradictions and cognitive dissonance as they relinquished these children to their biological families.

How did these parents define the foster parenting experience? Medical foster families perceived and defined their experience through both private and social definitions of reality. Reality is socially constructed and ordered in a way that allows for observation and analysis. "Every individual requires the ongoing validation of his world, including the validation of his identity and place in this world by those who are truly significant others" (Berger, 1977, p. 7). Medical foster parents gained validation of their identity through different levels of social interaction. Friends, family members, professionals, biological parents, foster children and other medical foster families became their "significant others" as they moved through the stages of the experience.

Children in Medical Foster Homes

The following children were cared for by medical foster families. The names are all fictitious to protect the anonymity of the subjects. Amy and Missy were returned to their biological parents after being in medical foster care for 23 months and for 14 months, respectively. Susan went from medical foster care to another foster care placement after 34 months in the program. The other four children were still in care when the study took place.

Two and one-half year old Amy was hospitalized with scald burns inflicted by a relative who was babysitting. After two months of hospitalization, Amy went home to her parents. However, her parents were unable to care for her properly and her burns soon became infected. She returned to the hospital, was transferred to a regional burn center and finally discharged to the care of a medical foster family (Foster, Davis, Whitworth, & Skinner, 1982).

Norman, age two, was born with hydrocephaly and a heart defect. Corrective surgery was accomplished, but his recovery was complicated by the need for a tracheostomy, a surgical opening into the trachea to facilitate breathing. He remained hospitalized from birth until 18 months of age. His mother, a single parent, was unable to provide a stable home or take responsibility for his tracheostomy care.

Susan was hospitalized at four week of age because of failure-to-thrive syndrome, a skull fracture, severe diaper rash and dehydration. She was found to have a cardiac defect which required corrective surgery. Postoperative complications led to a tracheostomy. At 12 months of age, she was discharged from the hospital to a medical foster home. Susan's mother, age 17, was retarded and considered by protective service case managers to be unsuitable for parenting responsibility because she had abused Susan in the past (Davis, Foster, & Whitworth, in press).

Missy at age 7 was found to suffer from failure-to-thrive syndrome and neglect and was placed in the hospital for

diagnostic evaluation. She went home to her mother. Multiple support services were provided to the family. Six months later, she was admitted to the hospital for emergency surgical removal of two pennies caught in her esophagus. A gastrostomy (a surgical opening into the stomach to enable tube feeding) was performed. Despite continued support services by a homemaker, a visiting nurse, and a protective service case manager, Missy was hospitalized again because of weight loss and neglect (Davis, Foster, & Whitworth, in press).

Bobby, age three, suffered severe second and third degree scald burns inflicted by his mother. The maternal grandmother attempted to provide care after Bobby was released from the hospital, but his injuries became infected, requiring re-hospitalization and grafting of the burn site. He went from the hospital into medical foster care.

Patty, a 16 month old twin was diagnosed as having nonorganic failure-to-thrive syndrome, severe depression and neglect. She was born prematurely to a mother with a history of depression and alcoholism. At 14 months of age, Patty was hospitalized for four weeks during which time she gained weight and began to socialize with others. When she returned home, multiple support services were provided to the family. She again exhibited signs of withdrawal, apathy and depression and was referred for medical foster care.

Barbara, a premature infant, developed bronchopulmonary dysplasia and chronic lung disease. She spent her first 11 months

of life in the hospital. At almost one year of age, she weighed eight pounds. Her parents were afraid to attempt her care due to the severity of her problems--she required oxygen, an apnea monitor, medication and frequent feedings. The mother, eight months pregnant and with a three year old daughter at home seldom visited. At 11 months of age, she was placed with a medical foster family.

The medical foster care program was created in response to a community need through the efforts of the Children's Crisis Center, Inc. (CCC) and the Department of Health and Rehabilitative Services (HRS). These children were being boarded in hospitals at a tremendous financial cost and to the detriment of their emotional, social, and physical development (Foster et al., 1982).

Medical Foster Families

At first glance, the medical foster families I came to know had few commonalities and marked differences. One parent in each family was a nurse. In seven of the families, the nurse was female; in one, the nurse was male. Seven of the families had children of their own ranging from toddlers to adolescents. Six families were white; two were black. One family lived in an older, urban neighborhood, located about ten minutes from the city hospital. One family lived in a small, stucco house on a busy street near a race track; another lived in a modern, two-story house nestled on a wooded lot in an exclusive suburban area. Other families lived in middle to upper class neighborhoods. The

education of medical foster families ranged from completing high school to a master's degree. Income and social status were diverse. Two of the foster fathers were military servicemen--one was an officer, the other, enlisted. One was a commercial airline pilot; one was in sales; another worked as an auto mechanic and one worked for the city. One parent was divorced; others described secure marriages while some marriages were reportedly fragile.

Typical medical foster parents were approximately 35 years of age with two children of their own. The nurse foster parents all had hospital clinical experience and four of them had completed baccalaureate nursing programs which included community health practice.

Anticipated Reality

We are our brother's keeper.

--Quote from a medical foster parent.

Pragmatic Motives

Recruitment of medical foster parents was accomplished through listings in the classified section of a local newspaper and in a professional monthly newsletter. The program was portrayed as a new alternative nursing practice for the at-home nurse. The advertisement stated that the program offered an opportunity for nurses as foster parents to use their nursing skills, earn money and remain at home.

As the data collection began, I asked the informants what were their motives for becoming medical foster parents, and all of the

nurses answered that they wanted to be able to stay at home and still continue the practice of nursing. The informants described their reasons for participating in the program by saying

> I can stay at home and earn money.
>
> It is a way to use nursing skills.
>
> It is an opportunity to provide nursing care in a different kind of environment; to stay home and be able to share with my family some of what I have been doing apart from them.

For those who had left the hospital setting to be at home with their own children, the program offered a way to return to nursing. They said

> I was looking for a change.
>
> I wanted to stay in nursing.

One informant said she wanted to see what the program was like; and another said, "I thought it might do something to enrich the marriage."

Such answers were pragmatic in nature and defined the medical foster parents' perspective from a practical sense. Many families said the timing was right. Their own children were "old enough." Old enough turned out to mean not so old to be disinterested; young enough to play; old enough to be somewhat independent (see Table 2).

The public view of medical foster care reinforced a pragmatic anticipated reality from a different perspective. The program is cost-effective, saving taxpayers approximately $9,000 per child per month. Thus, there were both social and private pragmatic sanctions for participating in the medical foster care program.

Noble Motives

All informants had more than one motive for becoming a medical foster parent. In addition to the pragmatic reasons were altruistic motives that were later conceptualized as noble act definitions. Research has shown that the hospital is no place to raise a child. In the eyes of physicians, nurses and social workers, medical foster parents "rescued" these children from a detrimental environment and brought them into a nurturing, home setting. The professional community was grateful for these "saints"; biological parents should be grateful; and certainly children should be happier in a home than in a hospital. Medical foster parents said

> I really like to help people, and I felt like this was a way of helping.
>
> I knew we had something to offer.
>
> It was a choice.

And from a mother of four school-age children who lived in an affluent suburban neighborhood

> I knew we had something to offer; I knew it would be somewhat of a sacrifice, but you have to do things in society; you have to give something back.

Such motives were closely akin to religious motives in effect. The intent, however, was to help meet societal needs as opposed to answering a religious calling. Medical foster parents made a cognitive choice, that was often a family decision, to help families who were less fortunate--to give something back.

Religious Motives

Religion played a prominent role in the lives of many of the medical foster families. They felt that medical foster parenting was a way to minister to God's children. A pervasive motive for taking on the responsibility of medical foster parenting rested on strong religious convictions. Informants revealed

> I really felt that I was led into it. I feel that God has a purpose for our lives, you know, and I feel like that was my purpose at that point.
>
> It can't be just a job . . . it has to be almost like a ministry.
>
> We feel like this is a mission.
>
> . . . what we were called to do.

A middle-aged couple, whose three year old medical foster child snuggled and kissed his substitute mother throughout the interview, captured the religious theme when they said, "We are our brother's keeper."

The anticipated reality of medical foster parents was conceptualized both privately and publicly. The medical foster care program brochures and manual describe it as a means for preventing inappropriate institutionalization of abused and neglected children. The program is geared to the at-home nurse. The cost effectiveness of the program was publicly sanctioned by the Department of Health and Human Services (HHS) through a federal grant.

Motives for medical foster parenting then were pragmatic, altruistic or noble, and religious. The medical foster families

expected that abused and neglected children would be happy to move out of hospitals and into nurturing home environments; that biological parents would be relieved, grateful and cooperative; and that the local District of Health and Rehabilitative Services (HRS) and the medical community would welcome their participation in the foster care program.

Privately, medical foster parents' reasons for participating in the program were a function of their anticipated reality of the situation.

Existential Reality

What have I done?

--Quote from a medical foster parent

Medical foster parents and other professionals with the program expected medical foster care to require a large measure of effort and clinical judgment but to be an enjoyable and rewarding experience. Prior to the placement of children, the informants attended foster parent classes that offered a format for discussing some of the adjustment problems often exhibited by children in foster care and methods for handling such problems. Medical foster parents seemed confident in both parenting abilities and coping skills. No one had foreseen or predicted what a shock the initial phase would bring once a child was actually put in the medical foster family setting.

In all but one situation, the medical foster parents saw the child prior to placement and discussed the case plan with

professionals involved in the care. In one instance, the nurse foster parent had never seen the child; she flew to a regional burn center in another state where she met Amy for the first time, finding her condition "much worse than I thought she would be."

Initial Reaction

Despite their preparation through participation in foster parent classes, attending planning conferences with physicians and nurses in hospitals and having the assurance of their own clinical competence, medical foster parents questioned the wisdom of their decision once the child's care became their full responsibility. I asked the informants what the situation was like at first, and their answers revealed a sense of fear, guilt, isolation, and an existential reality characterized by "what have I done?"

> If I had to pick one feeling--I was frightened, really frightened.
>
> When I brought him home, I thought--what have I done!--I didn't know what to expect . . . I was sorry I had done it.
>
> It was really rough, day and night; I wondered what am I getting myself into?
>
> I felt removed from the world, like I'd never get out again.
>
> I was lonely . . . exhausted.
>
> I didn't know which way to go.
>
> I was so upset; I was ready to pull my hair out and throw in the towel.
>
> The first night I brought her home, I said, what hath God wrought!

The initial response of medical foster parents could be compared to the way new parents react to their first born

infant when they bring him home. The overwhelming emotion was fear.

And children who "should" be happy to be out of the hospital instead produced turmoil. They went through their own stages of adjustment that lasted from several days to weeks.

> She was whiney and manipulative, demanding and wasn't going to cooperate with all the wonderful things I was going to do for her.
>
> At the beginning, he cried for three days. He was hostile . . . he said, get out of here!
>
> I went in there (at night) and he had his bandage off . . . and was scratching and there was all that blood all over the bed.
>
> I would find her in a soaking bed (from the wound drainage) and have to sponge her and re-dress her.
>
> The first two weeks, she'd get up and get into anything in the refrigerator and eat it . . . sometimes she made it to the bathroom; other times I heard her in the hallway throwing up.
>
> You can imagine taking any two year old into your house, but compound the medical problems with the months she was institutionalized before she came and the trauma--it's just unbelievable.

Rather than giving the anticipated feedback of love and appreciation, children failed to reflect the message "you're doing o.k." to medical foster parents. Instead the children cried, bled on the sheets and tore off dressings.

Medical foster parents' behaviors those first few days and nights centered around the children's unending care. They were afraid to sleep through the night without checking on their condition.

> He wanted to be rubbed, so we took turns rubbing for hours.
>
> I lost weight and lost sleep.
>
> We set the alarm in the middle of the night to check her dressings.
>
> I suctioned when it wasn't even necessary at first.
>
> We were up day and night.
>
> . . . I woke up whenever he coughed (child with a tracheostomy).
>
> At first we had him on the apnea monitor . . . and we were up a lot because we didn't know what to expect.

Families were filled with uncertainty to the point that they were preoccupied with the care of medical foster children. One couple put their one year old foster child in their bedroom to sleep to make sure they could hear her breathe.

> . . . and her tracheostomy plugged with mucous once during the night, but I heard her because she was in the room with me.

One family had to earn the confidence of their foster child who screamed when they attempted to tube feed her or change her dressings. These procedures were not at all painful, but it took almost two weeks before she stopped putting up a fight. They said

> We had to hold her down to tube feed her and at the same time convince her we wouldn't hurt her. And she cried, "My mommie don't do this to me."

The medical foster parents were confident of their ability to provide nursing care but found the emotional strain difficult to tolerate.

Worries During Initial Phase

What did medical foster parents worry about during the first phase of care? Their concerns were focused on the physical aspects of responsibility, what others would think and on the survival of the child. They said

> Worrying about her skin was probably the worst stress at all; what if it breaks down--what will I do if it does?
>
> I worried about her losing weight, I was not used to forcing food on her.
>
> I worried about infection, separation of his graft, and I was worried to death--those people (at the Children's Crisis Center) will kill me--they will think I'm a poor mama.
>
> . . . having her in the next room, knowing the tracheotomy had plugged up before and she had a respiratory arrest (in the hospital) never knowing whether you were going into the room and find that!
>
> . . . everything, you worry about everything. I said, she won't ever get well.

The first few weeks of foster parenting stood in stark contrast to the noble expectations that motivated informants to become foster parents. From a pragmatic sense, the nurses were at home, but in actuality they had no time for anyone else but the medical foster child. One parent described her around the clock nursing care.

> When you work in a hospital, you are there for eight hours and you can throw all of yourself into a job and you can really care about the patient, but you leave at the end of your shift. And someone else takes over the responsibility of the patient. In this situation, there is nobody else to take over the responsibility and it goes on for the next eight hours and the next and you wake up with it thn next morning. That's just her medical care--in the home, you're also rearing the child as well.

The initial phase of the medical foster care experience was characterized by fear and uncertainty. Medical foster parents questioned their ability to live up to their own anticipated expectations.

Hospitalism

Furthermore, abused and neglected children who had been socialized to hospital life for much of their existence behaved in peculiar, unexpected ways. There were both physical forms of regression and psychosocial symptoms associated with long-term hospitalization. Medical foster parents were not only shocked by the severity of their foster children's illness, but also by the inappropriateness of their behavior.

> She was calling every woman, "mommie."
>
> She was very people oriented. She didn't play with toys, wasn't interested in books. She responded to direct stimuli and that was about it.
>
> She didn't know what "I love you" means.
>
> He did not see people eating in the hospital, so he didn't know how to pick things up and put them in his mouth. He didn't know he was supposed to chew--he had been on strained food in the hospital and bottles (at 18 months of age). That's all he ever had.
>
> She shows a lack of direction--she just wanders off; she went to a neighbor's house after being told to stay home.
>
> He wanted someone in view at all times.
>
> His hospital bed was soft and that is where he was most of the time--he could fall back and not get hurt. He falls back (on the floor) and hits his head.

> . . . his legs are small and weak (at age 18 months).
>
> She never laughs.
>
> When she came, she couldn't sit up at all (at 12 months of age).
>
> . . . he was quiet, wringing his hands like and old man . . . he'd be laying down there listening to that music and his mind going, and I wondered if he was going over what happened to him.
>
> She was stubborn--just to be ornery. But from being in the hospital for so long--they have no discipline.

Not only were these children difficult to care for, they were difficult to understand, to discipline, and even to love. They had to be resocialized into a family environment where they could learn to relate on a personal level to parental figures and other members of the medical foster families.

Unalterable Routine

Bringing a medical foster child into a family interrupted the continuity and changed the equilibrium of the family system. One medical foster father, described the impact of bringing a burned child into the home.

> Well, she's put us in a routine that's unalterable . . . every day she has to be soaked; she (the medical foster mother) spends over an hour with her every morning; it has to be done every week, every day. Sleep is important, so her nap is unalterable; nutrition is important, so her meals are unalterable.

Other medical foster parents' answers echoed the demands of an unalterable routine.

> You can't just pick up and go somewhere.

> You're really tied down--it really locks you in.
>
> You have to think twice before you do anything. You have to consider how long you're going to be gone, when you're going, what kind of systems are available, if you need to take a suction machine, are you going to have a place to plug it in where you won't disturb other people.
>
> This is not something I can go home and leave . . . this is something I have to go home to.
>
> We couldn't go out to eat either--because of her mental status, she would throw a fit, make a scene.

The care of these children prevented families from making impromptu decisions involving family activities. Instead, such events were calculated around the fixed routines of medical foster children.

Attachment Versus Distancing

In spite of the demands and family disruptions that result from parenting a medical foster child, the participants became emotionally attached to these children. When asked if they felt bonded to medical foster children, the responses were generally affirmative. The bonding occurred in a variety of ways. Some parents felt an immediate surge of affection; others held back to some degree.

> I just sort of weighed it in my mind and decided that I would just give everything I had to her and would worry about the separation and all later . . . .
>
> . . . the first time I saw her I felt an attachment; no I did not distance myself--I still don't.
>
> I did bond with her--I still feel a bond with her, a certain amount . . . .

> Lot of that is just my feelings toward infants . . . I bond with them. I don't know whether it's maternal . . . she was "my baby" when I had her.

> We treat him just like ours--he is ours . . . he calls us mama and daddy; he was easy to love.

For some of the informants, the attachment was primarily emotional, but for others, the decision was a conscious choice. One couple told me

> We wouldn't have taken him if we weren't going to give all ourselves. We didn't have to do it.

Another medical foster parent also described the choice as a cognitive process. She said

> I really learned that love is a decision. I've said that time and time again but haven't had to put it into practice very often. She was a child I was not even sure I was going to like when she first came here. She was so difficult and unmanageable.

Some medical foster parents said they knowingly kept a little distance in the relationship. One medical foster father expressed his behavior this way.

> Because I know Amy's parents, I am aware that I'm not the father. So even though I try to treat her as fairly and give as much as I would my own child, I always know she isn't. I'm a little hesitant to--I don't want to replace them. I want her to be able to go back. And so I withhold just a little, just enough.

Others agreed for the same and for different reasons.

> . . . to a certain degree I did distance myself because I knew she would go back.

> I think there is sort of a bond, but nothing like you have with your own child.

> You realize he's not yours; nor is he the same race.
>
> It's not like a normal child would be because she didn't respond . . . not like a normal child.
>
> She wouldn't learn. She was destructive.
>
> . . . I knew it was not a lifetime commitment. I always felt the best place for that child was in that biological family.

The degree of closeness was influenced by variables such as the presence of biological parents, racial difference, age of the child, permanent placement plans and the ability of a child to respond to the medical foster family. In all but one family, both medical foster parents reported feeling some emotional attachment to the medical foster child. Only one medical foster parent said her husband never bonded with the child.

Unexpected Situations with Biological Parents

Phenomenological analysis of the subjective experience of medical foster parenting revealed numerous situations that were unexpected. One of the areas involved conflicted relationships with biological parents. "Every social relationship requires objectivation--a process by which subjectively experienced meanings become objective to the individual . . ." (Berger, 1977, p. 11). The subjectively experienced meanings of biological and foster parent relationships came out of a process of role definition.

In each situation, biological parents agreed verbally and in writing to the placement of their child in a medical foster home. The procedure for voluntarily placing children in foster care was

carried out through adjudicatory hearings which gave the court jurisdiction over the care of these children. Because biological parents agreed to the placement, both informally and through the formality of the court, medical foster families expected biological families to be willing participants in the treatment plans. Prior to placing a child in a medical foster home, both biological and foster parents had an opportunity to meet and establish some sense of each other's assigned roles and to set the stage for a beginning relationship. Despite such careful preparation, biological parents' initial behaviors and attitudes were surprising. Medical foster parents described their frustrations.

> When I first encountered her (at the burn center) we had a very difficult time with one another. I was trying to focus in on getting acquainted with the child. At the same time, I was extremely concerned about learning how to take care of her physcially, and . . . I found myself in a very competitive relationship with the mother.
>
> . . . our role with the parents--it didn't work out with Missy's mother.
>
> Norman's mother got angry the very first day--the day we brought him home. She got mad because I told her she couldn't return the next day to visit. That was on top of everything, the confusion.
>
> Bobby's grandmother sits and "primps" when she visits. I told her she has to learn how to take care of him. But she doesn't do anything on her own.

Foster and biological parents went through a process of moving into unfamiliar roles that have no common definition in

the culture but are rather defined by government agencies that are themselves empowered by law. Thus, the two families approached one another in general uncertainty yet with the knowledge that "officials of the state" had expectations for how they should behave and for what they should do.

Home Visits

Biological parents were court ordered to visit their children in the foster family homes. Visits turned out to be erratic and often unproductive in the opinion of medical foster parents. The court requires the interaction and yet, in the end, families must forge a human reality for they are living in an emotionally charged sequence of events.

> They came to visit without calling, brought along a friend and a six pack of beer; arrived at five o'clock; left for dinner, returned and stayed until eleven watching television.
>
> They told Amy they're going to leave--forty-five minutes later they were still there. So she was having a terrible adjustment the entire time--"are they leaving--are they not?"
>
> . . . they were bringing her candy. We were trying very hard to get protein in her.
>
> She (the biological mother) was being irritable towards my son . . . he didn't understand. He didn't do anything wrong. You could hear her telling him, "Put that down--don't take that away from Norman."
>
> She would call and set up appointments for me to pick her up at her sister's house and she wasn't living there. And she wouldn't tell me where she was living.
>
> . . . she thinks I'm responsible for all the child's actions; when she comes to

> visit, she sits and plays with the child and that's it.
>
> . . . she comes over and expects me to wait on her.

Often times biological parents failed to visit and neglected to give anyone notice not to expect them. Medical foster parents described their frustration.

> She was coming three times a week and then slacked off to once a week.
>
> There was a period of at least six months in which they didn't visit at all.
>
> Missy's mother didn't have much transportation. But when she wanted to go somewhere, when she wanted to go out of town, she found transportation.

As the data have shown, foster parents bring to the situation a whole array of motivations, good intention, and unrealistic expectations. Biological parents come with the knowledge that they have lost the custody of their children and often that they have been deemed inadequate by the state. The two families are brought together through court action and assigned roles that are reinforced by state agencies.

Feelings When Biological Parents Did Not Visit

At fist medical foster families experienced relief when biological parents stayed away. They said

> I was glad, because I needed to establish a pattern with the child myself before I can tell her how to handle Patty--or possibly what kind of schedule to have with the child.
>
> In a way, it was a relief because the first few encounters were difficult. None of us really knew how to act.

But soon the relief turned to worry, frustration and anger. The informants described their anguish in this way.

> Do they think she's better off with us?
>
> Are they afraid?
>
> . . . we were thinking they did not care, did not want her.
>
> There were times I would get very angry with them because I was trying very hard to keep them alive in her mind. They didn't have to worry about her--they didn't have to feel any responsibility for her because they knew we were doing it.
>
> And then there was that period of time I remember we thought, are we going to end up adopting this child, because they obviously don't care.
>
> She's just another person that happens to come along now and then. She's nothing special because she doesn't know how to be a mother. She can do mechanical things--she doesn't kiss him. She doesn't hug him, she's rigid.

The socially constructed definition of self that resulted from the initial phase of interaction with biological parents was revealed by a medical foster parent who said, "In effect, I'm the only mother that she has." Biological families often failed to visit and those who did needed prodding to take on a parenting role.

Foster Parents' View of Biological Parents

Finding a common ground for relating with one another was problematic for families. Attitudinal differences contributed to the tenuous state of relationships. Medical foster parents described the differences.

> We come from different lifestyles, different amounts of responsibilities, and totally different schedules and values. And beyond our imagination, the differences in the two kinds of ways we see life. They were in poverty--they were incapable of prioritizing; incapable of planning, not future oriented--they were crisis oriented. We wanted them to be able to think about the future, plan with us--and they couldn't do it. They don't think about the consequences of what they're doing.
>
> . . . they saw us as living in a soap opera . . . they felt so strange in our surroundings.
>
> She's unable to make a personal commitment toward even one realistic goal.
>
> I would not choose her (the biological parent) to be my friend--yet I have to allow her to come into my home . . . she sees other people as being there for her benefit--'if there's anything at all you can do to help me out, then I expect you to do it.' That's her attitude.
>
> She's not the least bit receptive. She did no more than she absolutely had to do.
>
> She felt we were intruders.
>
> She's a hard person to reach. . . . angry, she's a very angry person.

Some biological parents were viewed as childlike, while others were seen as victims themselves. Medical foster parents gave their assessments.

> She was on the level of a four year old.
>
> She functioned like a child, jealous of her own child.
>
> . . . a trip and a half, she's terrible immature.
>
> . . . another child as far as I'm concerned.
>
> She's overwhelmed--eight children, no money, no car and her husband left. She tried.

> She's a very dependent person and he's abusive.
>
> . . . a loving person who wanted to help people; I understood her.
>
> We feel sorry for her; she's overwhelmed, not strong.

Biological families of the abused and neglected children who came into medical foster care were viewed by medical foster parents and by social agencies as chaotic and unable to meet the basic tasks of families (Duval, 1977). According to Tapia's (1972) model for family nursing, such families function at the infancy or childhood level of development and are unable to promote the growth of family members.

Medical Foster Family Relationships

The addition of a medical foster child influenced the relationships among the members of the medical foster families. Sometimes siblings became closer and family relationships were strengthened. Different responses were seen in children of the medical foster parents. For example, one might take on a maternal relationship while another would respond more like a sibling.

> I think their (two sisters, ages 11 and 14) relationship was strengthened. They needed each other. They were able to see what they could contribute and that sort of defined for them who they were.
>
> The youngest helped me 'cause she wanted to. She enjoyed it.
>
> . . . basically they knew they were part of the program. They knew they were giving up something to help as well as I was.

> She (daugher, aged seven) used to call her "my sister," and she was really proud of her. But the older one didn't want me to bring Susan to her school. Kids when they're in middle school and teenagers can be kind of harsh.
>
> I think we were closer together then than we ever had been because we had a common goal for which we were working. We were more concerned about the child than we were ourselves.

Siblings in medical foster families expressed concern for the medical foster children and wondered what happened to them when they were hospitalized periodically.

> My kids are almost five and three, and they have become very attached to her. It was upsetting for them that she had to stay in the hospital.
>
> My son, aged five, asked me last night, "are we taking him to the hospital because he's being bad?"

Generally, medical foster family relationships were strengthened when all the members felt they were working together for a worthwhile cause. But for others, the experience caused a significant strain on family relationships. When I asked probing questions about what kinds of pressure the addition of a medical foster child produced, informants said

> She dominated everyone's life.
>
> My husband was jealous . . . he resented it. He was saying--"get her out of here, I don't want her here any more."
>
> . . . he wasn't interested in helping at all. He said, "what have you gotten into?"

The intrusion of biological parents also had a wearing effect on foster family systems. Foster parents coped with the

demands in ways that met the needs of the children but competed with the time couples had for each other.

> I felt like the biological mother was there all the time. I was seeing more of her than I see of my husband.
>
> He (the medical foster father) spends more time with our daughters because of Amy and a lot less time with me.

Medical foster family relationships were both strengthened and strained as a result of conflicting demands. Furthermore, other unforeseen stressors emerged in the foster parenting process that had an impact on family systems.

Stressors

Multiple stressors were associated with time needed for child care, travel and ambivalence over conflicting responsibilities of attending to the needs of two families. Medical foster parents listed stresses such as

> Making eight trips to a burn center in another state . . . .
>
> Making fourteen trips to a hospital in a city 80 miles away for overnight stays . . . .
>
> The trips were a big problem, to go down there two or three days and be concerned about her. I always felt if she were my own child, I wouldn't have left her in the hospital. But that meant leaving my kids.
>
> I'd be at the grocery store and the tracheostomy would plug up and I'd have to change it, right there.
>
> . . . she will hold formula in her mouth for at least a half hour if she feels like it without swallowing. It can take a couple of hours to get three ounces in her.

Neither the medical foster families nor other professionals in the program had fully appreciated the extent of commitment the care of these children would require. Families were confronted with obligations beyond the everyday nursing care. They felt responsible for the children whether they were at home or in the hospital. Furthermore, they had to be prepared for emergencies and willing to take whatever amount of time was necessary for nursing children back to health.

Contradictions in the Bureaucracy

There were unforeseen contradicitons in the bureaucratic systems that medical foster families had to confront. There were problems with payment schedules, poor communication, and lack of professional recognition.

> Nobody contacted me about the performance agreement. I didn't know anything about it until they said--here, sign it. So I was kind of forced into letting her visit all these hours. I felt "tricked." What could I do?
>
> You have to fork out money ahead of time and wait for a month or six weeks or own a major credit card.
>
> He's been here almost two full months and I haven't seen a penny.
>
> . . . my name wasn't in the computer.
>
> Money was a problem . . . and it was slow in the beginning. It took about two months and Susan didn't have any clothes and she needed extra food and all sort of things.
>
> We never see a social worker.
>
> We had a problem getting to the social worker. We were supposed to be getting information that we never got about Missy's medical appointments.

> And there was a breakdown in communication and what she wrote in her report was not what we said.

There were communication problems with physicians and hospital staff. Medical foster parents complained that they were treated as parents, not nurses.

> I think that's an absolute necessity if nurses are going to be part of the team; they really need to know the medical history.
>
> I had a problem with communication with the doctor.
>
> I asked at the hospital before I took him home, could I read the chart and they said 'no' they would not let me read the chart.
>
> The nurses would not hand the chart over to me.
>
> . . . she had experienced a seizure and was on phenobarbital for a year and I didn't have that information either.

All the nurse foster parents had expected to be given professional recognition comparable to that of nurses in hospital and community agency settings. Instead, they were treated as foster parents who were not privy to medical information. They jokingly considered donning white uniforms, caps and pins as a means of gaining ready entry into the health care system.

Feedback From Outsiders

There were unexpected comments by others that contributed to the existential definitions of medical foster parents. When I asked what relatives and friends said to them about becoming medical foster parents, they replied

Most of them thought we were saints which was difficult. We didn't feel like saints.

A physician said to me, "My wife could never do that because she would love the child too much." And those kinds of things are painful and I wanted to say, "You don't think I love this child too much!" My package response was, I don't think people are aware of what they can do.

We got some funny looks some times--actually disgusted looks.

My father said, "What's that?"

. . . if we went out to eat, we would usually tube feed Missy before we went. And we would get her jello or some such thing. And people would say, "Why are you not feeding the child?" And we'd say, "Well she has this special problem." And they'd pity her and try to give her money.

I disliked people saying that they couldn't do it because you know they could . . . . It was also flattering in some ways, but "aren't you wonderful because you take the child" bothered me.

. . . they'd make comments and stare all the time and I had to get used to that.

. . . people wouldn't sit around me anymore like they used to (when the medical foster parent watched her children play soccer).

. . . people thought we were weird--"what in the world are you doing?"

People would say, "How old is your baby?" I'd answer that she is eleven months old and they'd say, "But she's so small!" And I'd have to explain.

My brother-in-law couldn't stand to be around her because of the tracheostomy, and that happened to two other people I know.

I used to take her into the grocery store quite a bit, and after a short while people talk to you about it. And it got to the point that everybody knew her and asked how she is doing.

> . . . and people were constantly saying, "What are you going to do when she leaves?" And I'm dealing with what are you going to do until tomorrow morning or next week--but not when is she going to leave, which is something we never knew.

In summary, the existential reality of the foster parenting experience was in contrast to the anticipated reality. Medical foster children were more acutely ill than foster parents imagined; their behaviors were peculiar, manipulative and sometimes hostile; their treatment schedules put families into unalterable routines that made them feel isolated, fearful and "tied down." On the other hand, families did respond to these children with love, with emotional parental attachment and with a feeling of responsibility that went beyond the everyday home care. The nurse foster parents stayed with foster children overnight in hospitals and accompanied them to medical centers in other cities or out of state leaving their own children with the father, relatives, or neighbors.

Family relationships were strengthened in some instances and strained in others because of the unexpected demands of both nursing and parenting medical foster children. Unexpected situations occurred with foster parent to biological parent interaction and with contradictions in bureaucratic systems.

Medical foster families got comments from friends, relatives and outsiders which added to their disquiet and subjectively experienced meanings of the situation. The first phase of the medical foster care experience was characterized by uncertainty and apprehension.

Routinization

Out of the chaos emerged a sense of order in the medical foster homes. Berger and Luckman (1966) pointed out that, "the reality of everyday life seeks to integrate the problematic sector into what is already unproblematic" (p. 24). Through habitation of activities, medical foster families established routines that provided them a sense of psychological relief (Berger & Luckman, 1966). They described the difference.

> Once I had gotten into a routine, I wasn't as physically tired. Once we got her sleeping through the night.
>
> Now that we're used to him, it's no different than if he didn't have any problems at all, because everything just gets done, just like he's always been here.
>
> She started making friends with children down the street. I could trust her.
>
> It was just like having a normal kid except she ate funny. We just lived a normal life and took Missy along and structured her feedings.
>
> It was a delight for everybody, once we were comfortable with her.
>
> We don't understand what we did before we had him and he's only been here a month.
>
> We treat him just like ours.
>
> It took several weeks for things to settle down to what is now the tolerable sameness of the routine.
>
> It took about three weeks.

Successful routinization was accomplished through definition of multiple roles of parent, spouse, nurse, advocate, and teacher.

Some tasks were performed by the nurse foster parent; others belonged to the spouse or siblings. Medical foster families defined this stage of reality both privately and through social interaction.

The Nursing Roles

Nursing tasks included tracheostomy care, gastrostomy care, tube feedings, suctioning, giving medications, performing chest percussion and postural drainage. Nurses as medical foster parents also made physical and psychosocial assessments, interventions and evaluations of children in their care.

> I am constantly assessing Amy. She was an emotional problem and behavioral and developmental--not being sure of where she was and what she had been exposed to and what her real needs were.
>
> . . . I came home and took one look at that kid (when she was taken from her biological mother) and I said, she doesn't belong here, she belongs in the hospital--they kept her ten days.
>
> We had to get her to trust us to do the same things they were doing in the hospital and realize that baths and cleaning and irrigations were necessary.
>
> I was making decisions that nobody else could make.
>
> . . . you have a professional responsibility to do the right thing.
>
> So I keep it clean (burned area of the child's back). I scrub it when I bathe him to dilate the vessels.
>
> I worried about her arm because we thought she had a contracture. And with working with her arm myself, she got it almost extended.

Medical foster parents carried out prescribed nursing tasks and also made independent nursing decisions on the basis of their assessments.

> . . . I have to soak, pick, then cut small areas of patches; wrap, use foam and a conformer. Her skin is healing since I called and got permission to remove the sponge . . . there is healing and breakdown, but I cut an area out of the jobst garment (a special elastic stocking type vest) to give more ventilation and avoid rubbing at the seam.
>
> I give full range of percussion with postural drainage. The respiratory therapist said to do it on his back, but I do full range . . . no, he's never had pneumonia.
>
> After I talked to another medical foster parent, I decided to put him in the bath tub--and he feels better and his skin looks better.

Routinization of nursing tasks was readily accomplished. Nurses gained confidence in this aspect of care and modified procedures to accommodate a child's particular needs. Nurses as foster parents became expert at caring for children with burns, tracheostomies or failure-to-thrive syndrome.

Medical foster parents also identified emotional needs of the medical foster children that were associated with their past life histories.

> When she first came to us, she smiled a lot, but she never laughed.
>
> Her affect was flat . . . she didn't know what "I love you" even means.
>
> When I take him to the bathroom and if he can't urinate, it upsets him . . . and I say "It's o.k. if you can't." And he doesn't want you to leave him alone in the bathroom.
>
> She didn't ask for anything--we had to anticipate all her needs. She just sat there, withdrawn.

Once the physical aspects of care were routinized, medical foster families attended more to the psychosocial needs of children in care. Foster fathers and siblings also participated in the process.

The Fathering Roles

Medical foster fathers participated in varying degrees in the ongoing care of these children. I asked if fathers got up at night to check on them and I found an intense level of love and family involvement with all but one medical foster father.

> The first night when we brought her home, he stayed up with her all night while he told me to go and get some sleep. And he stayed up and he would watch her and he lay down on the floor next to her.
>
> Yes, we both get up because we're one really. And we want Bobby to be as comfortable with one as he is with another.
>
> Both of us wake up. I think he has gotten up when I didn't hear Norman.
>
> Oh, he loves her . . . he'd babysit with her . . . if she needed suctioning, he knew how to do it.
>
> I kept her when my wife went to the store, and she had trouble breathing, and I gave her oxygen.

Most medical foster fathers helped in a variety of ways: with mealtime, giving baths, dressing the children, playing with them, taking walks to the playground. They helped with transportation of biological parents and made trips to hospitals.

Medical foster mothers did take on the major responsibility for care, however, even when the fathers knew how. They reported

> He can do all the medical care because I have taught him how. He will do it--but I do most of it. When we're here together, I'm the one who will pick Norman up and suction him when he needs it.

In one family, the husband rarely participated in the care. His wife reluctantly admitted

> He never got up with anybody . . . he would let me do it, but he wasn't interested in helping at all. But we made fourteen trips out of town for her hospitalization and he had to pitch in then.

In most families, medical foster fathers routinely contributed to the care of their children and the foster child. Even in the family where the father did not habitually participate, he took on additional family responsibility when the medical foster child required hospitalization in another city.

The Sibling's Roles

I asked what roles biological children of the medical foster parents played in the care of children in their homes and how did they feel about what they had to do.

> . . . it would have been a lot harder without them, because they really entertain her.
>
> They really enjoy participating in her development and somewhat in her physical care--because play is very important for Susan.
>
> . . . they had to share their parents, their time, their home, their possessions. They were perfectly aware of what we were doing as a family.
>
> They knew we were doing this out of love . . . they expressed a willingness to do that and to share.
>
> . . . and the kids played with her and we talked about what they needed to do with her, and they spent a lot of time stimulating her emotionally. And it was neat!
>
> They knew that their playing with her and giving their time made a difference.
>
> She picks him up and hugs and kisses him like we do.

Siblings also routinized their roles by playing with medical foster children, sharing their parents' attention and sometimes helping with the foster child's physical care. In some medical foster families, the siblings were teenagers who learned how to assist in the nursing care. They learned how to feed, suction or bandage even though they were not given that kind of responsibility.

Coping Mechanisms

Through routinization and a period of "settling in," medical foster families began to reestablish a new equilibrium. Coping mechanisms and support of significant others were also incorporated into the routinziation. I asked families what were their coping strategies and they said

> We lived a day at a time--a week at a time.
>
> . . . things like prayer, our church life, the support of our church family--not only supporting us but reaching out to Amy and including her in their life.
>
> . . . friends, neighborhood friends. And my parents came up and took care of my girls.
>
> I prayed . . . the neighbors helped me at one point, once in a while. My sister helped.
>
> . . . the case coordinator was the one I dealt with mainly. I talked to another medical foster parent on the phone and that's what pulled us through. She told me what to do.
>
> . . . she's compulsively organized.
>
> I said, "Lord, you led me into this and I know your're real, and so you're going to have to watch over her at night--I've got to sleep, you know."

Neighbors, friends, relatives, church members and case coordinators from the Children's Crisis Center became the

"significant others" who participated in the routinization stage of the experience. Religious faith continued to provide the strength that for many foster parents was at the center of their coping repertoire.

Part of the routinization included learning how to cope with the health care system in order to manage multiple hospital admissions and frequent clinic appointments. Informants said

> You check in on Sunday afternoons because it is not very busy. It is easy to get her checked in. Then have her dilitation on Monday and she can go home on Tuesday.

> And like I had to take Susan into the hospital for a doctor's appointment, and the case coordinator would get me right in.

> We made eight trips--one was an overnight; one was for three days that I spent learning how to take care of her; then I was there for a week when she had her second surgery.

Visits to medical centers for follow-up evaluation became routinized to the point that one foster parent would leave home with her foster child early in the morning, fly to a regional burn center in another state 1500 miles away, have the child evaluated by a team of professionals and return home that same evening.

Defining the Territory

Routinization of the nursing role was accomplished with less difficulty than the parenting and advocacy roles. Trying to be both a nurse and a parent was not easy. Amy's medical foster mother explained her inner turmoil.

> There were lots of times as a nurse I had to hurt Amy and it made it difficult in my role as a parent. I was the only one in the family

> having to hurt her. So her foster father and foster sisters could have a relationship with her that I wasn't sure I could have . . . I was the one who was with her the most and I was doing the limit setting.

Furthermore, the conditions that were in the best interest of the medical foster child often conflicted with requests of biological parents. The medical foster families said

> I told her, my job is to protect the child.

> We couldn't be both the child's advocate and the biological parents' advocate.

> We were having a problem in figuring out our own roles when we were trying to be for them and at the same time we were trying to be for Amy.

As medical foster parents defined their roles during the routinization phase, agency professionals also had to clarify their positions. A psychologist was added to the staff to counsel and be an advocate for biological families; foster care case managers spoke for the children through performance agreements and court hearings, while case coordinators and the medical foster care project coordinator worked closely with medical foster families to add to their support system.

Routinization was a cultural theme that occurred on different levels of social interaction in the fostering process. Routinization took place in family relationships, nursing care and in dealing with bureaucratic systems. But the routinization phase was not static; medical foster families moved back and forth as biological families seemed to take "two steps forward and four steps backward," according to one of the informants. Routinization of the child

into the home did appear to be a necessary prerequisite to successfully attending to the needs of biological parents.

Social Reconstruction of Reality

> And she gave back to us.
>
> --Quote from a medical foster parent

As the children became a part of the medical foster family system and grew healthier physically, families began to attend to improving negative behaviors. Through consistency in love and discipline, children responded dramatically. When I asked what medical foster parents did to change behaviors, they told me

> When I took her to church meetings, there were lots of toys--she started whining. I took her aside and told her when she stopped whining, she could play. She cried about three minutes then played for over 30 minutes with the toys. Now she plays happily when she goes.
>
> Love him, talk to him, kiss him. What he needs is a family to take care and love him . . . I look at him real hard (to discipline); I say, if you do that, you can't go outside. I told him--since you've been so helpful, I'm going to take you to get some ice cream.
>
> She was so difficult and unmanageable. But that has all fallen into place once she got into a structured environment and a consistent environment. She was able to develop into quite an extraordinary little child.

Even when the foster parents gave nursing care, they were improving negative behaviors through validation of feelings and giving choices. I observed and listened one day as Amy soaked in the tub, then had her burns debrided, patched and wrapped. The medical foster mother would say

> Show me how you wiggle your fingers; now show me how you move your shoulder--bend your elbow--good.
>
> Where do you want me to wash first?
>
> Why are we doing this?
>
> I know you're cold.
>
> What's going to happen next?
>
> O.K., you pick there and I'll pick here.
>
> I know that's a sore area.
>
> I'll put some lotion on as soon as we finish.
>
> What do we do now?
>
> You do it--it doesn't hurt as much if you do it.
>
> That's better--I'm glad.

Medical foster parents taught songs and rhymes and colors to children. One family found that music helped to calm their three year old foster child. They said that he would lie down quietly, listen to songs and even learn the words.

As medical foster parents began to see improvement in the children's status, they were reluctant to entrust the care to others. They said

> I felt a little bit protective. I knew her routine; I was so intimately involved with her skin and the function of her body, I didn't really want to give up the care.
>
> She was so fragile--we rarely had babysitters.
>
> I hated to send him out.
>
> She didn't heat his food, even though I had written down instructions.
>
> Susan had an IV in her foot that infiltrated, in the hospital, and I thought I'm not going to leave her anymore.

> It was hard to leave her with babysitters. I would always have that tension and stress you know--what if something happens.

Because of their "intimate involvement" with the care of these children, nurse foster parents became possessive of their care. No one else could live up to their level of expectations, not even another nurse foster parent who babysat on occasion.

Rewards of Medical Foster Parenting

Caring for medical foster children brought rewards as children's physical and psychosocial status improved and they started to give positive feedback. Medical foster parents said

> She's happier, more playful. She shows more personality.
>
> He's cheerful, talks more, shares, plays.
>
> She talks to you now like she belongs.
>
> He calls us Mama and Daddy.
>
> My most rewarding experience was the first night she stood up and walked over to me and said, "I love you, too, Mommie."
>
> The socialization for my son is very good for him . . . and there's the benefit of just seeing a child grow, because Norman's learned so much since he's come here. It's really unreal.
>
> I tell you, that was one of the high points in my life watching Missy respond . . . . That's it--watching Missy blossom.
>
> The feeling that you've helped someone, a child who would have to be in the hospital otherwise. And seeing her respond to people.
>
> Susan touched the lives of all the people she was exposed to.

> . . . her color has improved; she's fun; she contributes.
>
> . . . she's growing taller; she's developed a sense of humor . . . she prided herself on being clean.
>
> And she gave back to us--it was delightful to see the world through the eyes of a toddler and to be able to enjoy and laugh with her and play with her and to teach her.
>
> Oh, she was marvelous. She was a different child. We asked her what was the first thing she wanted when she came home (after surgical repair of the esophagus) and the first thing was a hamburger . . . She never ate jello again. She just had that grin on her face, and she was so thrilled and excited. That was a really high point.

Medical foster parents received positive feedback from the children themselves and from health care professionals, from the court and from members of the Children's Crisis Center. The social interaction at this stage of the experience led to a reconstructed definition of reality. The existential reality began to match the anticipated reality. Children were at last providing the anticipated feedback of "you're doing o.k."

Keeping Biological Family Ties

Medical foster families who successfully routinized the care of children to the point that such care was no longer problematic could then turn their attention more to the needs of biological families. They told me their reasons for keeping such ties.

> We wanted them to want her.
>
> And I thought it was important--because she was black also--to keep those ties going. And I was the only one who could do it because she wasn't making any effort to do it.

> We thought she was going back and we wanted to keep those ties going.
>
> He asks for her at night--he calls her Lollie; I didn't know who that was at first.
>
> And there were lots of time that maintaining the ties with her parents meant saying, "Mommie loves you and Daddy loves you," and it would stick in the throat. But it was the thing we felt we had to do and we did.
>
> I think the minute she gets that tracheostomy out she needs to go back into that family, because they still want her; and she is that child in that family.
>
> We really do believe that is where she belongs--she is a Roberts and she will always be a Roberts.

Foster care is designed to provide temporary out-of-home placement until biological families can resume the responsibility for their children. Because medical foster families believed that children belong with their biological families, they tried to promote biological family/child bonding. The effort, however, was often one-sided, when biological families failed to call or visit.

Use of External Controls

In an effort to motivate biological families to comply with performance agreements and to take advantage of community services being offered, external controls from the court, from the foster care case manager and from medical foster families were necessary. Medical foster parents explained

> At the beginning, the only thing that was successful was authoritarian intervention . . . they responded to authoritarian behavior, they had very clear, rigid, concrete roles within their family. It was not until we said, 'yes or no; do 1, 2, 3, 4, 5' and they did it.
>
> We did ultimately set some limits . . . . We sat them down and said, "You know, there are other ways that you can bring her things and express your love without bringing her candy."
>
> I showed her the performance agreement that said she was to participate in the care-- and she did it.
>
> I told her it would help her to talk to the counselor . . . and I said, but you learn new things, that's all. They're trying to teach you new things about yourself.
>
> It was a good month or maybe even longer before I sat down and said, o.k., now these are the things I see you do and these are the things that are not positive for the child. And I wrote them down.
>
> I think she (the biological mother) made a lot of strides when she really felt she was going to lose Missy; she started working for her. It's kind of bad to get Missy as a reward for good behavior, but that is what happened.
>
> They knew at that point that if we got angry enough, that they were in trouble. Because they knew they had the court order.

Medical foster parents found that modeling desired behaviors was insufficient as a teaching method for effecting change in the behavior of biological families. In addition, they had to use a directive approach that included specific instructions and explicit goals. Furthermore, the external control of the court was required to promote frequent interaction of biological parents with their child and with medical foster families.

Ways to Enhance Relationships

According to Tapia (1972) the establishment of a trusting relationship with the chaotic family is "the most important nursing activity in the therapeutic process, yet a most difficult one" (p. 269). I asked the informants what were some ways they enhanced the relationships with biological families and they said

> . . . she was still calling them Mommie and Daddy, so maybe they had lost a little of that fear.
>
> I just tried to go in there that first meeting and just be there. I didn't try to contradict anything she said or anything she did.
>
> I was able to share with her how I viewed our situation and tried to reassure her that . . . it was o.k. for her to love us and be a part of our family, that no one was ever going to take the place of her mother.
>
> When their relationship began to deteriorate, she needed somebody to talk to and she would call me and let me know what was going on. And we would share that . . . She just began to view me as a big sister.
>
> We let her stay here with Norman while we went to church.
>
> I picked her up (the biological mother) and we went to the doctor's office. And I had her go in there with me and I tried to keep the ties.
>
> I told her, I'm not going to take your baby away from you--you know that don't you?
>
> She was invited to a party and she asked me exactly what to wear. I offered her a dress of mine.

Through the process of working with biological families through parent-to-parent interaction, some changes were noted. Medical foster parents described the improvement they saw.

> There were things going on in sort of a pattern that led me to believe we were having an influence on them. She was beginning to care what she looked like . . . some of their behavior changed with Amy. And their communication with each other and with Amy was better.
>
> She sees herself different now--as my friend.
>
> She has gotten an apartment . . . and in the past month, she's started to pick him up and hold him close and give him a kiss now and then and even hug him. And she no longer calls him "rat face."

Through a slow and sometimes arduous process of relationship building, medical foster parents became "significant others" in the lives of biological parents. Gagne (1977) pointed out that one of the conditions for human modeling is that a person be "admired, respected, or perceived as having 'credibility' . . ." (p. 245). Medical foster parents earned both the respect and trust of biological parents. The next step was to reinforce behavioral changes that biological families began to demonstrate. Reinforcement occurred through the transitional phase of the experience.

Transition Phase

As medical foster children's physical status continued to improve and biological families also demonstrated better parenting behaviors, children were allowed to go home for brief visits. The visits produced a sense of ambivalence in the medical foster

families depending on the state of the children when they returned.

> When she first started going home, her arm reopened again. That was almost to be expected, in fact, we made a decision that a little bit extra skin care was worth re-establishing the bond with the family.
>
> Missy would go spend a few hours with her mother and brother and come back and we could see just after a few hours the regression. The flat affect would come back--she would say, "hold me, hold me."
>
> She kept him for the weekend without any problem, but it always seems to me . . . that he's not as plump when he comes back--he looks thinner and is harder to deal with.
>
> We began to transition her home, starting her out one night, then two nights in a row--that kind of thing. So she was actually home four days and three nights for about three weeks, the rest of the time back with us.
>
> . . . she came back and was in good condition and seemed to emotionally adjust.

In two situations, plans for returning children were carried out and then had to be re-evaluated. Susan did go home to an aunt for about six weeks but was then readmitted to the hospital with pneumonia. Amy was also in the process of returning home when a family crisis occurred with her biological parents and she was returned to her foster home abruptly. Medical foster families experienced shock, disappointment and guilt over the failures.

> I had carried most of her things home. She was living more at home than at our house. And the night this particular crisis happened, she had to be returned immediately to our home . . . I was in a state of shock.

> When Susan went to her aunt, even after all the training and the aunt felt very competent, there were some areas that we missed. Susan was not one hundred percent well. That would not have been a problem except that she was going to a pediatrician who didn't know the child . . . and the second problem was that the back up person the aunt had did not turn out to be a back up.
>
> After that hospitalization, she was in her home for a week before she was in the hospital again, and that's when another medical foster parent and I went down there and said to the aunt, "Don't you think you've had enough?" I was disappointed we didn't get her back in the home, because I felt that was where she needed to go.

The transition phase reawakened a sense of uneasiness among medical foster families. On the one hand, they believed that their goal was to return children to their biological families; to that end, they permitted children to spend brief periods of time with biological families on a trial basis. On the other hand, medical foster families worried about the quality of care children received when they were away. When biological families failed to live up to the expectations of others, medical foster families shared in the disappointment.

Confrontation of Biological Parents' Reality

> We took a piece of coal, polished it into a diamond with a flaw to return to the coal bin.
>
> --Quote from a medical foster parent

At the point the medical foster children were happiest and healthiest and contributing to the family systems, medical foster families and professionals involved in the program had to

confront the reality of biological parents afresh. As families began to go through the motions of separating from the medical foster children, their private, subjective view of the situation was often different from the public face they wore.

> Most everything I said came out of my head . . . my heart was breaking and I knew the things I had to do. And I said to her one night, "When you go home to your Mommie and Daddy, you are not coming back to our house." She was smart enough that if she went home and things didn't go right, she would use it and say, "I'm going back" . . . and worse than that, I was afraid that inside she would believe that.
>
> Privately we said different things, but to Missy we said, "You'll be going home."
>
> We knew this was it--we were losing her this time. So we cried a lot and I was trying to tell her why I was crying. I was going to miss her, but it was going to be good--she was going to see her sisters and it was going to be just wonderful. All this kind of stuff I said, none of which I really believed.

Medical foster families tried to the best of their ability to prepare children for the future. Foster parents felt very much alone with such an enormous task. There were no prescribed methods, no assurances--just the knowledge that the time was right for foster children to be returned to their parents.

Disengagement Process

The medical foster families went through a painstaking phase of extricating themselves from the foster children. For some, this stage was complicated by the need for friends, relatives and church members to go through a similar disengagement. Medical foster families described the experience.

> A few months before she left, I went through a phase trying to separate myself from Susan--I think you do that, so that helped. And even taking her to the day care facility every day, that was a form of separation . . . before that, she and I were inseparable, I mean always together.
>
> We had friends that she had to be disengaged from. She had my family--my parents became very much attached to her. She was their granddaughter and they were concerned ab out where she was going and why.
>
> I took her to church to have communion one last time and our priest asked if we had consídered fighting for her. And I said no . . . I just didn't see that we had that right.

Siblings and the medical foster child also had to face the inevitable moment of separation.

> The night before she left . . . our daughter had said to Amy, "You're going to see your mommie and daddy! You're going to go live with them!" And Amy said, "Me no want to go nowhere." So she pulled away and our daughter came downstairs to me and cried her eyes out, which she needed to do.

Medical foster parents, siblings and foster children had to "disentangle" themselves in an effort to prepare for children to return to biological families. There were moments, however, when all the preparation seemed worthwhile.

> I went to the airport and found the mother and she looked marvelous. I'd never seen her look that good. She was dressed nicely, her hair was adorable; she looked great. I told her that Amy might be a little hesitant at first, but that would be o.k. Just give her some time. And I told her the kinds of things I thought she needed to hear.
>
> And then Amy came in--she looked at her mother and I could just see the little wheels turning in her mind. And almost as if--she took a deep breath and ran toward her mother. And her mother picked her up and burst into tears. And that

> made me happy, it really did. That's how we started two years ago--at an airport with her mother in tears.

Worries When Medical Foster Children Leave

All families have to confront the loss of children when they grow to adulthood and move through the process of emancipation (Edelstein, 1981). But when medical foster children, still dependent on others for their care, left the medical foster families, those families were uneasy about what the future held. The decision to return medical foster children to biological families was made on the basis of the children's health status and each biological family's ability to take on the responsibility for parenting. The final decision was determined by the court. Medical foster parents explained what they worried about when foster children were returned to their biological parents.

> She will be getting less than optimal care, whereas now she is getting the highest quality of care. Can she survive with adequate care?

> I was most concerned about whether she missed us. I was most concerned about her emotionally--she was physically o.k.

> . . . but we are afraid her mother won't watch her carefully.

> Nobody said she's doing well and she's fine--it's just she's o.k., whatever that means . . . . We don't know she's doing all right because we haven't seen her.

> I don't think the foster mother is too bonded with Susan. Her attitude is not too good. Her daughter and her granddaughter help her a lot. That's the only way Susan's survived this--being older like she is.

> The only thing I am concerned about is anger. . . . She will not discipline him . . . She's going to get him home 24 hours a day and 7 days a week and one day she's going to go "boom" and not be nice to him anymore. And what is she going to do?
>
> It's one of those things she's going to have to realize that Amy can't go running down the street like every other kid because her skin is more vulnerable.

Medical foster families worried about the physical and psychosocial needs of their foster children. And they wondered what kind of adjustment children would make in a less-than-optimal environment.

In effect, medical foster children had become bicultural as a result of the experience. After spending a year or more in the foster family setting, these children spoke a different language, used a different approach to problem solving and took a different view of their world.

> She was so verbally superior to her family at this point, not only in the words she used but the kinds of things that she was able to express in her feelings; her understanding of things that were going on around her that I'm not sure anybody else paid any attention to. And I was concerned about her getting lost in the middle of her family.
>
> There will be a tremendous adjustment--she does not speak in the language of her family.

Medical foster families worried about the quality of care children would receive and were uneasy about their emotional adjustments. The informants were well aware that for a time, medical foster children were exposed to cultural advantages, effective parenting and unconditional love that were in stark contrast to what the future was apt to hold.

Formal Confrontation of An Informal Concern

Medical foster families informally considered keeping the medical foster children at times when biological families seemed unable to comply with even the most basic family responsibilities. One medical foster parent revealed

> We really had to come to a decision as to whether we would keep her if it came to that.

In another instance, the medical foster family was so distraught over the child's return to her biological parent that they hired an attorney to represent the interest of the child in court. Later they explained

> That was a gesture--maybe a grand gesture--but it attracted attention which is what we wanted. It set a precedent to hire an attorney as a friend of the court for the child.

Professionals involved in the case recommended that--in the best interest of the child--she be returned to her biological family; a decision with which the court concurred. Subsequently, the relationship between the two families was severed. The medical foster father expressed his reaction.

> We missed the kid--we still miss her, because we spent the most time with her and the most energy. And it hurt--I didn't hurt so much because I miss her, I hurt because of what the child missed--that was a big disappointment, what she was missing.

The complex issue of quality of life was the focus of one medical foster family's formal confrontation of what for many families was an informal concern. "Younger children, then, are always dependent on adults; the question is which adults are to

be recognized as representing the children's best interest" (Berger & Berger, 1983, p. 70). Sociologically, the question of judgment was one of upper middle class values and to what extent they should be imposed on a family with different values (Berger & Berger, 1983).

Dissonance

Following the return of medical foster children to biological families, the medical foster families had to come to grips with their feelings of dissonance in an effort to find some degree of existential peace. In one situation, there was still a sense of ambivalence over unfinished business, because the family never successfully disengaged from the medical foster child. Other families were able to find comfort through their religious faith and through the knowledge that they did their best. Their feelings of disquiet were evident when they explained

> Our hope was that when she did go back to her mother, that what we gave her would stick with her--I am not so sure it will. We hoped her mother's situation would improve and that what we gave her culturally would provide something for her to grow with.
>
> I grieved for the situation she was going to; she's not in the best of situations, but she's surviving. I was very ambivalent . . .
>
> We've had several reports from people who see her once in a while who say she is just a little street urchin--dirty.
>
> I have not gone over there. I sent her one Christmas card--I didn't even send her a Christmas card this year.
>
> I was relieved at first. I felt quite a bit of freedom after she left. But I did call her,

> like the first week I called her a few times. I saw her on her birthday and on holidays I'd go by. In the beginning when she left I'd see her more frequently, then I spaced it out--just for Susan's sake. Because when I'd go there, she was real excited and she would just bolt out the door--'mama, mama!' She called me mama and she liked seeing me . . . It's been almost a year since she left and I kept her this weekend. And she didn't call me mama.
>
> We had a hard time at Christmas. She'd been with us for two holiday seasons. And we went to a toy store to get something for one of our children, and we had to leave . . . because we walked around looking for the toys for children that age and realized we didn't have anybody to buy them for.
>
> . . . there's no way to fill that void. I'm not sure it should be filled.
>
> We had decided we were going to stay out of her life and that God would just have to take care of her . . . this is what we believed and it helped us at those times we would wonder and begin to hurt a little bit--to just lay aside . . . .

Medical foster parents coped with their feelings of dissonance in different ways. Some chose to stay out of the life of their foster child while others watched over the child from a distance. Holidays and birthdays reawakened the sense of loss.

Existential Meaning

As Blumer (1969) pointed out, "Social interaction is obviously an interaction between people and not between roles; the needs of the participants are to interpret and handle what confronts them . . . ." (p. 75). An informant whose foster child had been returned to the biological family, articulated the medical foster family's interpretation of the existential meaning of the experience.

> And I think we had the feeling as a family that we had really laid our lives out and there were no guilts; there were no "I wish I had" and "I wonder if."
>
> We knew that we had taken a child who was hurting and we had some measure of success with her inner healing, with her physical healing. She was well parented for the time period that she needed to go through.
>
> So having the feeling that we had done what we were called to do and had done what we had meant to do, all we could do was hope that it had given her a foundation that she could carry back into that family and function well with it.

Confrontation of the biological parents' reality was an essential stage in the foster care experience. Acceptance of that reality was inevitably fraught with ambivalence. In the early stages of interaction between medical and foster families, the informants recognized marked cultural differences between them. Through counseling, role modeling, directive intervention and parent education, some positive gains were made by biological parents. Improvement was observed in communication patterns, discipline, parenting skills and even their general appearance. The lifestyle of the biological parents may never be congruent with that of the informants in this study, but that is not at issue. The belief that children belong with biological families, when they can provide safe care, guided the medical foster parents through the final stage of the experience.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

Medical foster care is a new concept of foster parenting designed to reduce inappropriate hospitalization of abused or neglected children, provide nurturing environments for children to regain their health and to strengthen biological families. The purpose of this enthnographic study was to ascertain what happens in the medical foster family setting from the foster parents' point of view and to examine the phases medical foster families go through.

The sample population consisted of eight medical foster families who met specific criteria. One of the foster parents in each family was a registered nurse. Each family expressed a willingness to accept a child needing medical care into their home, and each family agreed to work closely with biological parents. At the time of data collection, the informants had had medical foster children in their homes from 3 weeks to 23 months.

Participant observation was used to collect ethnographic data. Data were gathered in fieldnotes, transcribed interviews, videotapes of medical foster parents and foster children, taped tape recordings of foster parent meetings and notes from court hearings. I interviewed each of the medical foster families in their homes using

the guiding question, What is involved in the process of becoming a medical foster parent? Preliminary questions that explored roles, relationships, phases of the experience, stresses and coping behaviors were asked through open-ended interviews. Data collection and analysis took place over a seven month period in which I made multiple home visits to medical foster families, accumulated almost 200 pages of typed fieldnotes and observed a variety of situations and events related to medical foster care. Data were analyzed in a cyclical fashion to discover new problems and questions to be asked.

Ethnographic analysis is a process of description and interpretation. Fieldnotes were examined to find cultural domains or "categories of meaning" (Spradley, 1980, p. 88). Taxonomic analysis showed relationships among the terms in each domain and componential analysis produced contrasting units of meaning. Analysis required both keeping a holistic view to find cultural themes and examining slices of data in detail.

Conclusions

Answers to Ethnographic Questions

Medical foster care is a process that involved social interaction and interpretation of the situation through the phases of the parenting experience.

What motivated nurses and their spouses to become medical foster parents? Pragmatic, noble and religious intentions were the primary motives behind the foster parenting experience. The nurses wanted to be able to stay at home with their families and still continue the practice of nursing. The informants expressed the desire to help

others who are less fortunate and to give something back to society. A pervasive motive for medical foster parenting rested on strong religious convictions and the willingness to fulfill a purpose in life.

What are the roles foster parents assume? Once children were placed in care, medical foster parents assumed the multiple roles of parent, nurse, advocate, teacher, colleague, spouse, foster parent and role model. The nursing role was readily routinized; parenting and advocacy roles were more difficult.

What are the phases of the foster parenting experience? Medical foster families went through sequential phases as they defined their roles. The phases of the experience went from an anticipated reality to an initial phase of existential reality that was characterized by fear, anxiety, guilt and feelings of isolation. A phase of routinization followed and then a social reconstruction of reality that was associated with positive feedback from the medical foster children and outsiders. Both the public and private definitions of reality mirrored the expectation that the children were responding to the care and that medical foster families were succeeding in reaching their goals. Only when medical foster families successfully routinized children's nursing care into their family system, were they able to focus their attention on the psychosocial needs of foster children and their biological families. The health of medical foster children triggered the next phase which required facing the reality of biological parents in an effort to return their children. Medical foster families went through phases of detachment and separation but in so doing experienced dissonance and existential contradictions.

Do medical foster parents bond to foster children? Medical foster families described feelings of emotional attachment and bonding to children in care, but some medical foster parents attempted to keep enough distance to facilitate the later return of children to biological families. Families whose medical foster child was matched to their preference of age, race, and sex or whose medical foster child gave positive feedback tended to describe more intense feelings of attachment than families whose medical foster child was not matched to such preferences or who was unable to respond "normally." Neither the phases of the experience nor the issue of bonding was static but could move back and forth.

How does having a medical foster child influence family activity and relationships? The addition of a medical foster child influenced family activity by putting families into an unalterable routine and by tying them down to the nursing care needs of the medical foster child. Family systems revolved around the care of the medical foster child. In some instances, triangulation of family members changed. Generally, the medical foster mother in each family took on the extra burden of care and responsibility for the medical foster child's well being.

What are the stresses medical foster parents experience in relationships with medical foster children, biological parents, family members and professionals, and what strategies are used to cope with such stresses? Stressors associated with the experience included medical problems, parenting responsibilities, lack of professional recognition, conflicts with biological families and contradiction in the bureaucratic systems. Medical foster families

coped with such stressors by organizing and routinizing care and by turning to relatives, friends, to their religious faith and to other professionals in the program for situational support.

What are the rewards of medical foster parenting? Watching medical foster children grow and develop and observing appropriate changes in the lives of biological families were the rewards of the experience. Positive feedback from outsiders reinforced the medical foster families' self-esteem and the notion that they were succeeding in accomplishing their objectives.

What are the behaviors described by medical foster families that enhance relationships with biological parents? Medical foster families invited biological families into their homes and lives as they worked to build trusting relationships with parents of children in their care. They provided transportation for clinic visits and court hearings and encouraged frequent home visitation. Medical foster families listened, advised and supported biological families as they made progress toward "borderline acceptable" family functioning.

What behaviors are exhibited by medical foster parents when they relinquish children and return them to their biological families? Medical foster families tried to prepare foster children for returning to their homes. The informants learned how to cope with situations experientially because there were no formal guidelines to direct them through the phases. Medical foster families felt they should not continue to be involved in the lives of the biological families when children first returned. However, when a medical foster child left, the informants described a void in their lives that was intensified at holidays and birthdays.

How do medical foster parents view dysfunctional parents whose children are in their care? Medical foster families viewed biological parents in the program as immature, dependent, overwhelmed and sometimes abusive--often in need of parenting themselves.

Recommendations

Professionals working with medical foster families need to recognize the importance of the phases families go through in the process of the experience. As medical foster parents work through the phases, they are going to have feelings of disquiet and uncertainty. Medical foster families should be helped to work through those phases with ample amount of support and the least possible amount of frustration. Anticipatory guidance can increase the awareness, visibility and structure of these phases in an effort to expand coping strategies of medical foster parents. Some medical foster families may not effectively routinize the care which will impede their ability to work successfully with biological families.

The goal of the program is for medical foster families to provide nurturing, therapeutic home environments for abused and neglected children with severe health problems and at the same time work with biological families to offer role modeling, parent education and advocacy. The preconceived expectation that medical foster families could attend to foster children's medical and social needs, resolve unanticipated conflicts with biological parents, the bureaucracy, and the medical community--and be a counselor, role model and parent advocate all at once--was unrealistic. While these goals are possible within the framework of the fostering process, such

expectations are naive until medical foster parents work through their own phases and problems and move from medical routinization to human care routinization.

The findings of this ethnographic study should warn professionals against routinization of the medical foster care program. After observing the patterns that medical foster parents to through, professionals in similar programs may be apt to intellectualize and categorize the phases and then routinize their responses. If phases of the fostering experience are defined as mere developmental phases, professionals may not give them the attention they deserve and participants may not get the support they need.

Medical foster parenting is a fragile balance of social interaction and interpretation. The need to give the social situation of medical foster care all the nurturing and care that is given to the medical situation is evident. This ethnographic study points that out and illuminates the parenting experience from the view of the medical foster family participants.

Program Improvements

This ethnographic study has served as an evaluation component for the medical foster care program. The findings show the need for interventions that reduce conflict and enhance the situational support for medical foster families. Therefore, in the future, biological and medical foster families will have ample time prior to the placement of a foster child to meet, discuss assigned roles and responsibilities, visitation schedules, and performance agreements. Biological parents will be invited into the medical foster family's

home prior to a child's placement so they can see where their child will be living. Once the child is in care, however, a medical foster family will be given a "settling in" period of at least three days before biological parents' first visit. This time will allow medical foster parents the opportunity to begin the routinization of nursing care without intrusion.

In an effort to enhance professional recognition of medical foster parents in hospitals and community agencies, name tags that include the title "R.N." and "Medical Foster Care" have been issued to the participants.

A clinical psychologist is responsible for evaluating and offering periodic counseling for each of the biological families. Group therapy for biological parents whose children are in medical foster care is also being scheduled. Increasing the input of the psychologist may decrease the magnitude of the responsibility placed on medical foster parents to counsel biological parents.

Group meetings of medical foster parents and members of the Children's Crisis Center are now scheduled on a monthly basis. In the past, such meetings had occurred infrequently. These meetings provide a format for foster parents to give input to the program coordinator and other agency professionals. In addition, the meetings provide a significant resource of situational support for medical foster families.

This ethnographic study has described the medical foster care experience from the view of medical foster parents. The findings of the study may be used to enahance the experience of others who assume responsibility for the care of abused and neglected children with severe health problems whose alternative is institutionalization in hospitals.

APPENDIX

APPENDIX

INFORMED CONSENT

Respondent's Name_____Protocol #_____

Project Title: Medical Foster Care: An Ethnography

Medical Foster Care is a pioneer concept of foster parenting. Because of its innovative nature, research is needed to explore the process of becoming medical foster parents, to ascertain what happens in the foster parent setting and to examine stages medical foster families go through as they define and internalize new roles. I am interested in exploring your perception of this experience which will aid in discovering the complexity of this treatment modality and generate hypotheses for future research.

In order to gain an in-depth understanding of medical foster parenting, I will set up appointments and interview you in your home so that we might explore roles, relationships, phases of the experience, stresses and coping behaviors. Repeated home visits may be necessary in order to complete the data collection, ask new questions that arise out of the data and in order to validate inferences, themes and patterns that emerge.

You may refuse to answer any question and you may withdraw your consent and participation in the research at any time. Your participation in the research is voluntary and is without payment.

Interviews will be taped and then transcribed by me in order to facilitate systematic analysis. Your responses will be confidential. To insure this confidentiality, your repsonses are never identified with your name, but rather with a six-digit number that will be on each form. Fieldnotes and interview data will be confidential and unavailable to other professionals associated with the program. I will destroy the tapes after they are transcribed. Data will be grouped according to themes and patterns that arise out of the analysis and pseudonyms will be used in fieldnotes and publications that result from the research.

I have read and I understand the procedure described above. I agree to participate in this study and I have received a copy of this description.

Signed:

_____	_____	_____	_____
Subject Interviewed	Date	Witness	Date
_____	_____	_____	_____
Relationship if other than Subject	Date	Principal Investigator's Name	Date

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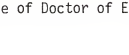
BIOGRAPHICAL SKETCH

Patricia Hatch Foster was born in Greensboro, North Carolina, on July 15, 1938. She graduated from Fayetteville Senior High School in Fayetteville, North Carolina, in 1956 and earned a Bachelor of Science in Nursing degree at Duke University in 1960. She married Malcolm T. Foster, Jr., and moved to Winston-Salem, North Carolina, where she worked as a public health nurse.

Patricia earned a Master of Science in Nursing degree at the University of Nebraska Medical Center in Omaha, Nebraska, in 1975. She joined the faculty of the Division of Nursing at the University of North Florida in 1978 and currently holds a rank of Assistant Professor. She has been a nursing consultant to the Children's Crisis Center since 1978. She and her husband and three children, Malcolm, Allison and David, reside in Jacksonville, Florida.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Education.



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I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Education.

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This dissertation was submitted to the Graduate Faculty of the Division of Curriculum and Instruction in the College of Education and to the Graduate School, and was accepted as partial fulfillment of the requirements for the degree of Doctor of Education.

August 1984

Dean for Graduate Studies and Research